TITLE 9. HEALTH SERVICES

CHAPTER 28. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ARIZONA LONG-TERM CARE SYSTEM

Editor's Note: The Office of the Secretary of State publishes all Code Chapters on white paper (Supp. 01-3).

Editor's Note: This Chapter contains rules which were adopted under an exemption from the rulemaking provisions of the Arizona Administrative Procedure Act (A.R.S. Title 41, Chapter 6, §§ 1001 et seq.) as specified in Laws 1992, Ch. 301, § 61 and Ch. 302, § 13, and Laws 1994, Ch. 322, § 21. Exemption from A.R.S. Title 41, Chapter 6 means that AHCCCS did not submit notice of this rulemaking to the Secretary of State's Office for publication in the Arizona Administrative Register; AHCCCS did not submit these rules to the Governor's Regulatory Review Council; AHCCCS was not required to hold public hearings on these rules; and the Attorney General did not certify these rules. Because this Chapter contains rules which are exempt from the regular rulemaking process, the Chapter is printed on blue paper. The rules affected by this exemption appear throughout this Chapter.

ARTICLE 1. DEFINITIONS

Former Section R9-28-101 repealed; new Sections R9-28-101 thru R9-28-111 adopted effective December 8, 1997 (Supp. 97-4).

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R9-28-706. Payments by the Administration for Services Provided to Eligible Persons
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ARTICLE 8. REPEALED

Article 8, consisting of Sections R9-28-801 through R9-28-803, repealed by final rulemaking at 10 A.A.R. 820, effective April 3, 2004. The subject matter of Article 8 is now in 9 A.A.C. 34 (Supp. 04-1).

Section
R9-28-801. Repealed
R9-28-802. Repealed
R9-28-803. Repealed
R9-28-804. Repealed

ARTICLE 9. FIRST- AND THIRD-PARTY LIABILITY AND RECOVERIES

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R9-28-901. Definitions
R9-28-902. General Provisions
R9-28-903. Cost Avoidance
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ARTICLE 10. CIVIL MONETARY PENALTIES AND ASSESSMENTS

Section
R9-28-1001. Basis for Civil Monetary Penalties and Assessments for Fraudulent Claims
R9-28-1002. Repealed
R9-28-1003. Repealed
R9-28-1004. Repealed

ARTICLE 11. BEHAVIORAL HEALTH SERVICES

Article 11, consisting of Sections R9-28-1101 through R9-28-1106, repealed; new Article 11, consisting of Sections R9-28-1101 through R9-28-1108, adopted by final rulemaking at 6 A.A.R. 200, effective December 13, 1999 (Supp. 99-4).

Section
R9-28-1101. General Requirements
R9-28-1102. Contractor Responsibilities
R9-28-1103. Eligibility for Covered Services
R9-28-1104. General Service Requirements
R9-28-1105. Scope of Behavioral Health Services
R9-28-1106. General Provisions and Standards for Service Providers
R9-28-1107. Standards for Payments
R9-28-1108. Grievance and Request for Hearing Process

ARTICLE 12. REPEALED

Article 12, consisting of Section R9-28-1201, repealed by final rulemaking at 10 A.A.R. 820, effective April 3, 2004. The subject matter of Article 12 is now in 9 A.A.C. 34 (Supp. 04-1).

Article 12, consisting of Section R9-28-1201, adopted effective September 9, 1998 (Supp. 98-3).

Section
R9-28-1201. Repealed

ARTICLE 13. FREEDOM TO WORK

Article 13, consisting of Sections R9-28-1301 through R9-28-1324, made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4).

Section
R9-28-1301. General Freedom to Work Requirements
R9-28-1302. General Administration Requirements
R9-28-1303. Application for Coverage
R9-28-1304. Notice of Approval or Denial
R9-28-1305. Reporting and Verifying Changes
R9-28-1306. Actions That Result From a Redetermination or Change
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R9-28-1309. Social Security Number
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R9-28-1318. Non Payment of Premium
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R9-28-1320. Additional Eligibility Criteria for the Basic Coverage Group
R9-28-1321. Share of Cost
R9-28-1322. Premium Amount
R9-28-1323. Enrollment
R9-28-1324. Redetermination of Eligibility

ARTICLE 1. DEFINITIONS

R9-28-101. General Definitions

A. Location of definitions. Definitions applicable to Chapter 28 are found in the following:

Definition	Section or Citation
"Administration"	A.R.S. § 36-2931
"ADHS"	R9-22-112
"Aggregate"	R9-22-107
"AHCCCS"	R9-22-101
"AHCCCS Registered Provider"	R9-22-101
"Algorithm"	R9-28-104
"ALTCS"	R9-28-101
"ALTCS acute care services"	R9-28-104
"Alternative HCBS setting"	R9-28-101
"Ambulance"	R9-22-102

"Applicant"	R9-22-101
"Bed hold"	R9-28-102
"Behavior intervention"	R9-28-102
"Behavior management services"	R9-20-101
"Behavioral health evaluation"	R9-22-112
"Behavioral health medical practitioner"	R9-22-112
"Behavioral health professional"	R9-20-101
"Behavioral health service"	R9-20-101
"Behavioral health technician"	R9-20-101
"Billed charges"	R9-22-107
"Board-eligible for psychiatry"	R9-22-112
"Capped fee-for-service"	R9-22-101
"Case management plan"	R9-28-101
"Case manager"	R9-28-101
"Case record"	R9-22-101
"Categorically-eligible"	R9-22-101
"Certification"	R9-28-105
"Certified psychiatric nurse practitioner"	R9-22-112
"CFR"	R9-28-101
"Clean claim"	A.R.S. § 36-2904
"Clinical supervision"	R9-22-112
"CMS"	R9-22-101
"Community Spouse"	R9-28-104
"Contract"	R9-22-101
"Contract year"	R9-28-101
"Contractor"	A.R.S. § 36-2901
"County of fiscal responsibility"	R9-28-107
"Covered services"	R9-28-101
"CPT"	R9-22-107
"CSRD"	R9-28-104
"Day"	R9-22-101
"Department"	A.R.S. § 36-2901
"De novo hearing"	42 CFR 431.201
"Developmental disability"	A.R.S. § 36-551
"Diagnostic services"	R9-22-102
"Director"	R9-22-101
"Disenrollment"	R9-22-117
"DME"	R9-22-102
"EPD"	R9-28-301
"Eligible person"	A.R.S. § 36-2931
"Emergency medical services"	R9-22-102
"Encounter"	R9-22-107
"Enrollment"	R9-22-117
"Estate"	A.R.S. § 14-1201
"Facility"	R9-22-101
"Factor"	R9-22-101
"Fair consideration"	R9-28-104
"FBR"	R9-22-101
"Grievance"	R9-22-108
"GSA"	R9-22-101
"Guardian"	A.R.S. § 14-5311
"HCBS" or "Home and community based services"	A.R.S. §§ 36-2931 and 36-2939
"Health care practitioner"	R9-22-112
"Hearing"	R9-22-108
"Home"	R9-28-101
"Home health services"	R9-22-102
"Hospital"	R9-22-101
"ICF-MR" or "Intermediate care facility for the mentally retarded"	42 CFR 483 Subpart I
"IHS"	R9-28-101
"IMD"	42 CFR 435.1009 and R9-28-111
"Indian"	42 CFR 36.1
"Institutionalized"	R9-28-104
"Interested Party"	R9-28-106
"JCAHO"	R9-28-101
"License" or "licensure"	R9-22-101
"Medical record"	R9-22-101
"Medical services"	R9-22-101
"Medical supplies"	R9-22-102
"Medically eligible"	R9-28-104
"Medically necessary"	R9-22-101
"Member"	A.R.S. § 36-2931
"Mental disorder"	A.R.S. § 36-501
"MMMNA"	R9-28-104
"Nursing facility" or "NF"	42 U.S.C. 1396r(a)
"Noncontracting provider"	A.R.S. § 36-2931
"Occupational therapy"	R9-22-102
"Partial care"	R9-22-112
"PAS"	R9-28-103
"Pharmaceutical service"	R9-22-102
"Physical therapy"	R9-22-102
"Physician"	R9-22-102
"Post-stabilization services"	42 CFR 438.114
"Practitioner"	R9-22-102
"Primary care provider (PCP)"	R9-22-102
"Primary care provider services"	R9-22-102
"Prior authorization"	R9-22-102
"Prior period coverage" or "PPC"	R9-22-107
"Private duty nursing services"	R9-22-102
"Program contractor"	A.R.S. § 36-2931
"Provider"	A.R.S. § 36-2931
"Psychiatrist"	R9-22-112
"Psychologist"	R9-22-112
"Psychosocial rehabilitation"	R9-20-101
"Quality management"	R9-22-105
"Regional behavioral health authority" or "RBHA"	A.R.S. § 36-3401
"Radiology"	R9-22-102
"Reassessment"	R9-28-103
"Redetermination"	R9-28-104
"Referral"	R9-22-101
"Reinsurance"	R9-22-107
"Representative"	R9-28-104
"Respiratory therapy"	R9-22-102
"Respite care"	R9-28-102
"RFP"	R9-22-106
"Room and board"	R9-28-102
"Scope of services"	R9-28-102
"Section 1115 Waiver"	A.R.S. § 36-2901
"Speech therapy"	R9-22-102
"Spouse"	R9-28-104
"SSA"	42 CFR 1000.10
"SSI"	R9-22-101
"Subcontract"	R9-22-101
"Utilization management"	R9-22-105
"Ventilator dependent"	R9-28-102

B. General definitions. In addition to definitions contained in A.R.S. §§ 36-551, 36-2901, 36-2931, and 9 A.A.C. 22, Article 1, the following words and phrases have the following meanings unless the context of the Chapter explicitly requires another meaning:

"ALTCS" means the Arizona Long-term Care System as authorized by A.R.S. § 36-2932.

"Alternative HCBS setting" means a living arrangement approved by the Director and licensed or certified by a regulatory agency of the state, where a member may reside and receive HCBS including:

For a person with a developmental disability specified in A.R.S. § 36-551:

Community residential setting defined in A.R.S. § 36-551;

Group home defined in A.R.S. § 36-551;

State-operated group home under A.R.S. § 36-591;

Group foster home under R6-5-5903;

Licensed residential facility for a person with traumatic brain injury under A.R.S. § 36-2939;

Adult therapeutic foster home under 9 A.A.C 20, Articles 1 and 15;

Level 2 and Level 3 behavioral health agencies under 9 A.A.C. 20, Articles 1, 4, 5, and 6; and

Rural substance abuse transitional agencies under 9 A.A.C. 20, Articles 1 and 14; and

For a person who is elderly or physically disabled under R9-28-301, and the facility, setting, or institution is registered with AHCCCS:

Adult foster care homes defined in A.R.S. § 36-401 and as authorized in A.R.S. § 36-2939;

Assisted living home or assisted living center, units only, under A.R.S. § 36-401, and as authorized in A.R.S. § 36-2939;

Licensed residential facility for a person with a traumatic brain injury specified in A.R.S. § 36-2939;

Adult therapeutic foster home under 9 A.A.C. 20, Articles 1 and 15;

Level II and Level III behavioral health agencies under 9 A.A.C. 20, Articles 1, 4, 5, and 6;

Rural Substance Abuse Transitional Agencies under 9 A.A.C. 20, Articles 1 and 14; and

Alzheimer's treatment assistive living facility demonstration pilot project as specified in Laws 1999, Ch. 313, § 35 as amended by Laws 2001, Ch. 140, § 1 and Laws 2003, Ch. 76, § 1.

"Case management plan" means a service plan developed by a case manager that involves the overall management of a member's care, and the continued monitoring and reassessment of the member's need for services.

"Case manager" means a person who is either a degreed social worker, a licensed registered nurse, or a person with a minimum of two years of experience in providing case management services to a person who is elderly and physically disabled or has developmental disabilities.

"Contract year" means the period beginning on October 1 and continuing until September 30 of the following year.

"CFR" means Code of Federal Regulations, unless otherwise specified in this Chapter.

"Covered Services" means the health and medical services described in Articles 2 and 11 of this Chapter as being eligible for reimbursement by AHCCCS.

"Home" means a residential dwelling that is owned, rented, leased, or occupied by a member, at no cost to the member, including a house, a mobile home, an apartment, or other similar shelter. A home is not a facility, a setting, or an institution, or a portion of any of these that is licensed or certified by a regulatory agency of the state as a:

Health care institution under A.R.S. § 36-401;

Residential care institution under A.R.S. § 36-401;

Community residential setting under A.R.S. § 36-551; or

Behavioral health service under 9 A.A.C. 20, Articles 1, 4, 5, and 6.

"IHS" means the Indian Health Service.

"JCAHO" means the Joint Commission on Accreditation of Healthcare Organizations.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective June 6, 1989 (Supp. 89-2). Amended effective July 13, 1992 (Supp. 92-3). Amended effective November 5, 1993 (Supp. 93-4). Section repealed; new Section adopted effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 5 A.A.R. 369, effective January 6, 1999 (Supp. 99-1). Amended by final rulemaking at 5 A.A.R. 874, effective March 4, 1999 (Supp. 99-1). Subsection (A)(69) amended to correct a printing error, filed in the Office of the Secretary of State August 13, 1999 (Supp. 99-3). Amended by final rulemaking at 6 A.A.R. 200, effective December 13, 1999 (Supp. 99-4). Amended by final rulemaking at 6 A.A.R. 2461, effective June 9, 2000 (Supp. 00-2). Amended by final rulemaking at 6 A.A.R. 3365, effective August 7, 2000 (Supp. 00-3). Amended by exempt rulemaking at 7 A.A.R. 4691, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 8 A.A.R. 444, effective January 10, 2002 (Supp. 02-1). Amended by final rulemaking at 8 A.A.R. 2356, effective May 9, 2002 (Supp. 02-2). Amended by final rulemaking at 8 A.A.R. 3340, effective July 15, 2002 (Supp. 02-3). Amended by final rulemaking at 9 A.A.R. 3810, effective October 4, 2003 (Supp. 03-3). Amended by final rulemaking at 10 A.A.R. 1312, effective May 1, 2004 (Supp. 04-1).

R9-28-102. Covered Services Related Definitions

Definitions. The following words and phrases, in addition to definitions contained in A.R.S. §§ 36-2901 and 36-2931, and 9 A.A.C. 22, Article 1, have the following meanings unless the context of the Chapter explicitly requires another meaning:

"Bed hold" means a 24 hour per day unit of service that is authorized by an ALTCS case manager or designee during a period of short-term hospitalization or therapeutic leave that meets the requirement specified in 42 CFR 483.12.

"Behavior intervention" means the planned interruption of a member's inappropriate behavior using techniques such as reinforcement, training, behavior modification, and other systematic procedures intended to result in more acceptable behavior.

"Respite care" means a short-term service provided in a NF or a home and community based service setting to an individual if necessary to relieve a family member or other person caring for the individual.

"Room and board" means lodging and meals.

"Scope of services" means the covered, limited, and excluded services under Articles 2 and 12 of this Chapter.

"Ventilator dependent," for purposes of ALTCS eligibility, means an individual is medically dependent on a ventilator for life support at least six hours per day and has been dependent

on ventilator support as an inpatient in a hospital, NF, or ICF-MR for at least 30 consecutive days.

Historical Note
Adopted effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 6 A.A.R. 2461, effective June 9, 2000 (Supp. 00-2). Amended by final rulemaking at 9 A.A.R. 3810, effective October 4, 2003 (Supp. 03-3).

R9-28-103. Preadmission Screening Related Definitions
Definitions. The following words and phrases, in addition to definitions contained in A.R.S. §§ 36-2901 and 36-2931, and 9 A.A.C. 22, Article 1, have the following meanings unless the context of the Chapter explicitly requires another meaning:

"Developmental disability" is defined in A.R.S. § 36-551.

"PAS" means preadmission screening, which is the process of determining an individual's risk of institutionalization at a NF or ICF-MR level of care, as specified in Article 3 of this Chapter.

"Reassessment" means the process of redetermining PAS eligibility for ALTCS services as appropriate, for all members.

Historical Note
Adopted effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 6 A.A.R. 2461, effective June 9, 2000 (Supp. 00-2). Amended by final rulemaking at 9 A.A.R. 3810, effective October 4, 2003 (Supp. 03-3). Amended by final rulemaking at 10 A.A.R. 1312, effective May 1, 2004 (Supp. 04-1).

R9-28-104. Eligibility and Enrollment Related Definitions
Definitions. The following words and phrases, in addition to definitions contained in A.R.S. §§ 36-2901 and 36-2931, and 9 A.A.C. 22, Article 1, have the following meanings unless the context of the Chapter explicitly requires another meaning:

"211" is defined in 42 CFR 435.211.

"217" is defined in 42 CFR 435.217.

"236" is defined in 42 CFR 435.236.

"Algorithm" means a mathematical formula used by the Administration to assign a member to an EPD program contractor when the member does not make a choice and does not meet the assignment-decision process.

"ALTCS acute care services" means services, under 9 A.A.C. 22, Articles 2 and 12, that are provided to a person who meets ALTCS eligibility requirements in 9 A.A.C. 28, Article 4 but who lives in an acute care living arrangement described in R9-28-406 or who is not eligible for long-term care benefits, described in R9-28-409, due to a transfer under R9-28-409 without receiving fair consideration.

"Community spouse" means the husband or wife of an institutionalized person who has entered into a contract of marriage, recognized as valid by Arizona, and who does not live in a medical institution.

"CSRD" means Community Spouse Resource Deduction, the amount of a married couple's resources that are excluded in the eligibility determination to prevent impoverishment of the community spouse, determined under R9-28-410.

"Fair consideration" means income, real or personal property, services, or support and maintenance equal to the fair market value of the income or resources that were transferred.

"Institutionalized" means residing in a medical institution or receiving or expecting to receive HCBS that prevent the person from being placed in a medical institution determined by the PAS under R9-28-103.

"Medically eligible" means meeting the ALTCS medical eligibility criteria under 9 A.A.C. 28, Article 3.

"MMMNA" means Minimum Monthly Maintenance Needs Allowance.

"Redetermination" means a periodic review of all eligibility factors for a recipient.

"Representative" means a person other than a spouse or a parent of a dependent child, who applies for ALTCS on behalf of another person.

"Spouse" means a person legally married under Arizona law, a person eligible for Social Security benefits as the spouse of another person, or a person living with another person of the opposite sex and the couple represents themselves in the community as husband and wife.

Historical Note
Adopted effective December 8, 1997 (Supp. 97-4). Amended effective November 4, 1998 (Supp. 98-4). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 369, effective January 6, 1999 (Supp. 99-1). Amended by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1). Amended by final rulemaking at 6 A.A.R. 2461, effective June 9, 2000 (Supp. 00-2).

R9-28-105. Program Contractor and Provider Standards Related Definitions
Definitions. The following words and phrases, in addition to definitions contained in A.R.S. §§ 36-2901 and 36-2931, and 9 A.A.C. 22, Article 1, have the following meanings unless the context of the Chapter explicitly requires another meaning:

1. "Certification" means a voluntary process by which a federal or state regulatory entity grants recognition to an individual, facility, or organization which has met certain prerequisite qualifications specified by the regulatory entity and which may assume or use the word "certified" in his, her, or its title or designation to perform prescribed health professional tasks.
2. "Quality management" is defined in 9 A.A.C. 22, Article 1.
3. "Utilization management" is defined in 9 A.A.C. 22, Article 1.

Historical Note
Adopted effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1).

R9-28-106. Request for Proposals and Contract Process Related Definitions
Definitions. The following words and phrases, in addition to definitions contained in A.R.S. §§ 36-2901 and 36-2931, and 9 A.A.C. 22 Article 1, have the following meanings unless the context of the Chapter explicitly requires another meaning: "Interested Party" means an actual or prospective offeror whose economic interest may be affected substantially and directly by the issuance of a request for proposals, the award of a contract, or the failure to award a contract.

Historical Note
Adopted effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1).

R9-28-107. Standards for Payment Related Definitions
Definitions. The following words and phrases, in addition to definitions contained in A.R.S. §§ 36-2901 and 36-2931, and 9 A.A.C. 22, Article 1, have the following meanings unless the context of the Chapter explicitly requires another meaning:

"County of fiscal responsibility" means the county that is financially responsible for the state's share of ALTCS funding.

Historical Note
Adopted effective December 8, 1997 (Supp. 97-4). Amended effective November 4, 1998 (Supp. 98-4). Amended by final rulemaking at 6 A.A.R. 2461, effective June 9, 2000 (Supp. 00-2). Amended by final rulemaking at 9 A.A.R. 3810, effective October 4, 2003 (Supp. 03-3).

R9-28-108. Repealed

Historical Note
Adopted effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 6 A.A.R. 3365, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 820, effective April 3, 2004 (Supp. 04-1).

R9-28-109. Repealed

Historical Note
Adopted effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 10 A.A.R. 1308, effective May 1, 2004 (Supp. 04-1).

R9-28-110. Reserved

R9-28-111. Behavioral Health Services Related Definitions
Definitions. The words and phrases in this Chapter, in addition to definitions contained in A.R.S. §§ 36-2901 and 36-2931, have the same meaning as specified in 9 A.A.C. 22, Article 1.

Historical Note
Adopted effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 6 A.A.R. 200, effective December 13, 1999 (Supp. 99-4).

ARTICLE 2. COVERED SERVICES

R9-28-201. General Requirements
In addition to the exclusions and limitations specified in this Article, services provided to a member are covered services if:

1. Medically necessary, cost effective, and federally reimbursable;
2. Coordinated by a case manager in accordance with requirements specified in R9-28-510;
3. The provider obtains prior authorization as required by a member's program contractor or by the Administration:
   a. Failure of the provider to obtain prior authorization is cause for denial.
   b. Services provided during prior period coverage are exempt from prior authorization requirements;
4. Provided in facilities or areas of facilities that are licensed or certified under Article 5 of this Chapter, or meet other requirements described in Article 5 of this Chapter;
5. Rendered by AHCCCS registered providers as permitted under this Chapter and within their scope of practice; and
6. Provided at an appropriate level of care, as determined by the case manager or the primary care provider.

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Section repealed; new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 2356, effective May 9, 2002 (Supp. 02-2).

R9-28-202. Medical Services
The Administration or a contractor shall cover medical services specified in 9 A.A.C. 22, Article 2 for a member, subject to the limitations and exclusions specified in Article 2, unless otherwise specified in this Chapter.

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective June 6, 1989 (Supp. 89-2). Amended under an exemption from the provisions of the Administrative Procedure Act effective March 22, 1993; received in the Office of the Secretary of State March 24, 1993 (Supp. 93-1). Amended effective November 5, 1993 (Supp. 93-4). Section repealed; new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 2356, effective May 9, 2002 (Supp. 02-2).

R9-28-203. Repealed

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective June 6, 1989 (Supp. 89-2). Amended effective July 13, 1992 (Supp. 92-3). Amended under an exemption from the provisions of the Administrative Procedure Act effective March 22, 1993; received in the Office of the Secretary of State March 24, 1993 (Supp. 93-1). Repealed effective September 22, 1997 (Supp. 97-3).

R9-28-204. Institutional Services

A. Institutional services are provided in:
1. A NF;
2. An ICF-MR; or
3. A facility identified in R9-28-1105(A)(1)(b), (B), or (C).

B. The Administration and a contractor shall include the following services in the per diem rate for a facility listed in subsection (A):
1. Nursing care services;
2. Rehabilitative services prescribed as a maintenance regimen;
3. Restorative services, such as range of motion;
4. Social services;
5. Nutritional and dietary services;
6. Recreational therapies and activities;
7. Medical supplies and non-customized durable medical equipment under 9 A.A.C. 22, Article 2;
8. Overall management and evaluation of a member's care plan;
9. Observation and assessment of a member's changing condition;
10. Room and board services, including supporting services such as food and food preparation, personal laundry, and housekeeping;
11. Non-prescription and stock pharmaceuticals; and
12. Respite care services not to exceed 30 days per contract year.

C. Each facility listed in subsection (A) is responsible for coordinating the delivery of at least the following auxiliary services:
1. Under 9 A.A.C. 22, Article 2:
   a. Attending physician, practitioner, and primary care provider services;
   b. Pharmaceutical services;
   c. Diagnostic services under A.A.C. R9-22-208;
   d. Emergency medical services; and

e. Emergency and medically necessary transportation services.

2. Therapy services under R9-28-206.

D. Limitations. The following limitations apply:

1. A private room in a NF, ICF-MR, or facility identified in R9-28-1105(A)(1)(b), (B), or (C) is covered only if:
   a. The member or has a medical condition that requires isolation, and
   b. The member's primary care provider or attending physician provides written authorization;
2. Each ICF-MR shall meet the standards in A.R.S. § 36-2939(B)(1), and in 42 CFR 483, Subpart I, February 28, 1992, incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments;
3. Bed hold days as authorized by the Administration or its designee for a fee-for-service provider shall meet the following criteria:
   a. Short-term hospitalization leave for a member age 21 and over is limited to 12 days per AHCCCS contract year, and is available if a member is admitted to a hospital for a short stay. After the short-term hospitalization, the member is returned to the institutional facility from which leave is taken, and to the same bed if the level of care required can be provided in that bed; and
   b. Therapeutic leave for a member age 21 and older is limited to nine days per AHCCCS contract year. A physician order is required for therapeutic leave from the facility for one or more overnight stays to enhance psycho-social interaction, or as a trial basis for discharge planning. After the therapeutic leave, the member is returned to the same bed within the institutional facility;
   c. Therapeutic leave and short-term hospitalization leave are limited to any combination of 21 days per contract year for a member under age 21;
4. The Administration or a contractor shall cover services that are not part of a per diem rate but are ALTCS covered services included in this Article, and deemed necessary by a member's case manager or the case manager's designee if:
   a. The services are ordered by the member's primary care provider; and
   b. The services are specified in a case management plan under R9-28-510;
5. A member age 21 through 64 is eligible for behavioral health services provided in a facility under subsection (A)(3) that has more than 16 beds, for up to 30 days per admission and no more than 60 days per contract year as allowed under the Administration's Section 1115 Waiver with CMS and except as specified by 42 CFR 441.151, May 22, 2001, incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments; and
6. The limitations in subsection (D)(5) do not apply to a member:
   a. Under age 21 or age 65 or over, or
   b. In a facility with 16 beds or less.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended subsections (A) and (D) effective June 6, 1989 (Supp. 89-2). Amended effective November 5, 1993 (Supp. 93-4). Section repealed; new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by exempt rulemaking at 7 A.A.R. 4691, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 8 A.A.R. 2356, effective May 9, 2002 (Supp. 02-2).

R9-28-205. Home and Community Based Services (HCBS)

A. Subject to the availability of federal funds, HCBS are covered services if provided to a member residing in the member's own home or an alternative residential setting. Room and board services are not covered in a HCBS setting.

B. The case manager shall authorize and specify in a case management plan any additions, deletions, or changes in home and community based services provided to a member or in accordance with R9-28-510.

C. Home and community based services include the following:

1. Home health services provided on a part-time or intermittent basis. These services include:
   a. Nursing care;
   b. Home health aide;
   c. Medical supplies, equipment, and appliances;
   d. Physical therapy;
   e. Occupational therapy;
   f. Respiratory therapy; and
   g. Speech and audiology services;
2. Private duty nursing services;
3. Medical supplies and durable medical equipment, including customized DME, as described in 9 A.A.C. 22, Article 2;
4. Transportation services to obtain covered medically necessary services;
5. Adult day health services provided to a member in an adult day health care facility licensed under 9 A.A.C. 10, Article 5, including:
   a. Supervision of activities specified in the member's care plan;
   b. Personal care;
   c. Personal living skills training;
   d. Meals and health monitoring;
   e. Preventive, therapeutic, and restorative health related services; and
   f. Behavioral health services, provided either directly or through referral, if medically necessary;
6. Personal care services;
7. Homemaker services;
8. Home delivered meals, that provide at least one-third of the recommended dietary allowance, for a member who does not have a developmental disability under A.R.S. § 36-551;
9. Respite care services for no more than 720 hours per contract year;
10. Habilitation services including:
    a. Physical therapy;
    b. Occupational therapy;
    c. Speech and audiology services;
    d. Training in independent living;
    e. Special development skills that are unique to the member;
    f. Sensory-motor development;
    g. Behavior intervention; and
    h. Orientation and mobility training;
11. Developmentally disabled day care provided in a group setting during a portion of a 24-hour period, including:
    a. Supervision of activities specified in the member's care plan;
    b. Personal care;
    c. Activities of daily living skills training; and

d. Habilitation services; and

12. Supported employment services provided to a member in the ALTCS transitional program under R9-28-306 who is developmentally disabled under A.R.S. § 36-551.

Historical Note

Adopted effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 2356, effective May 9, 2002 (Supp. 02-2).

R9-28-206. ALTCS Services that may be Provided to a Member Residing in either an Institutional or HCBS Setting

The Administration shall cover the following services if the services are provided to a member within the limitations listed:

1. Occupational and physical therapies, speech and audiology services, and respiratory therapy:
   a. The duration, scope, and frequency of each therapeutic modality or service is prescribed by the member's primary care provider or attending physician;
   b. The therapy or service is authorized by the member's contractor or the Administration; and
   c. The therapy or service is included in the member's case management plan.
2. Medical supplies, durable medical equipment, and customized durable medical equipment, which conform with the requirements and limitations of 9 A.A.C. 22, Article 2;
3. Ventilator dependent services:
   a. Inpatient or institutional services are limited to services provided in a general hospital, special hospital, NF, or ICF-MR. Services provided in a general or special hospital are included in the hospital's unit tier rate under 9 A.A.C. 22, Article 7;
   b. A ventilator dependent member may receive the array of home and community based services under R9-28-205 as appropriate.
4. Hospice services:
   a. Hospice services are covered only for a member who is in the final stages of a terminal illness and has a prognosis of death within six months;
   b. Covered hospice services for a member are those allowable under 42 CFR 418.202, December 20, 1994, incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments; and
   c. Covered hospice services do not include:
      i. Medical services provided that are not related to the terminal illness; or
      ii. Home delivered meals.
   d. Medicare is the primary payor of hospice services for a member if applicable.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective June 6, 1989 (Supp. 89-2). Amended effective July 13, 1992 (Supp. 92-3). Amended effective November 5, 1993 (Supp. 93-4). Section repealed; new Section adopted effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 2356, effective May 9, 2002 (Supp. 02-2).

ARTICLE 3. PREADMISSION SCREENING (PAS)

R9-28-301. Definitions

A. Common definitions. In addition to definitions contained in A.R.S. Title 36, Chapter 29, and 9 A.A.C. 28, Article 1, the words and phrases in this Chapter have the following meanings for an individual who is elderly or physically disabled (EPD) or developmentally disabled (DD) unless the context explicitly requires another meaning:

"Acute" means an active medical condition having a sudden onset, lasting a short time, and requiring immediate medical intervention.

"Applicant" is defined in A.A.C. R9-22-101.

"Assessor" means a social worker as defined in this subsection or a licensed registered nurse (RN) who:

Is employed by the Administration to conduct PAS assessments,

Completes a minimum of 30 hours of classroom training in both EPD and DD preadmission screening (PAS) for a total of 60 hours, and

Receives intensive oversight and monitoring by the Administration during the first 30 days of employment with ongoing oversight.

"Chronic" means a medical condition that is always present, occurs periodically, or is marked by a long duration.

"Constant or constantly" means at least once a day.

"Current" means belonging to the present time.

"Disruptive behavior" means inappropriate behavior including urinating or defecating in inappropriate places, sexual behavior inappropriate to time, place, or person or excessive whining, crying or screaming that interferes with an applicant's or member's normal activities or the activities of others and requires intervention to stop or interrupt the behavior.

"Frequent or Frequently" means weekly to every other day.

"Functional assessment" means an evaluation of information about an applicant's or member's ability to perform activities related to:

Developmental milestones,

Activities of daily living,

Communication, and

Behavior.

"History" means a medical condition that occurred in the past that may not have required treatment and is not now active.

"Immediate risk of institutionalization" means an applicant or member under A.R.S. § 36-2934(A)(5) and as specified in the Administration's Section 1115 Waiver with CMS.

"Intervention" means therapeutic treatment, including the use of medication, behavior modification, and physical restraints to control behavior. Intervention may be formal or informal and includes actions taken by friends or family to control the behavior.

"Medical assessment" means an evaluation of an applicant's or member's medical condition and the applicant's or member's need for medical services.

"Medical or nursing services and treatments" or "services and treatments" in this Article means specific, ongoing medical, psychiatric, or nursing intervention used actively to resolve or prevent deterioration of a medical condition. Durable medical equipment and activities of daily living assistive devices are not treatment unless the

equipment or device is used specifically and actively to resolve the existing medical condition.

"Occasional or occasionally" means from time to time such as less than once per week during the assessment period.

"Physical participation" means the applicant's or member's active participation.

"Physically lift" means actively bearing some part of an applicant's or member's weight during movement or activity and excludes bracing or guiding activity.

"Physician consultant" means a physician who contracts with the Administration.

"Social worker" means an individual with two years of case management-related experience or a baccalaureate or master's degree in:

Social work,

Rehabilitation,

Counseling,

Education,

Sociology,

Psychology, or

Other closely related field.

"Special diet" means a diet planned by a dietitian, nutritionist, or nurse that includes high fiber, low sodium, or pureed food.

"Toileting" means the process involved in an applicant's or member's managing of the elimination of urine and feces in an appropriate place.

"Vision" means the ability to perceive objects with the eyes.

B. EPD. In addition to definitions contained in subsection (A), the following also applies to an applicant or member who is EPD:

"Aggression" means physically attacking another, including:

Throwing an object,

Punching,

Biting,

Pushing,

Pinching,

Pulling hair,

Scratching, and

Physically threatening behavior.

"Bathing" means the process of washing, rinsing, and drying all parts of the body, including an applicant's or member's ability to transfer to a tub or shower and to obtain bath water and equipment.

"Continence" means the applicant's or member's ability to control the discharge of body waste from bladder or bowel.

"Dressing" means the physical process of choosing, putting on, securing fasteners, and removing clothing and footwear. Dressing includes choosing a weather-appropriate article of clothing but excludes aesthetic concerns. Dressing includes the applicant's or member's ability to put on artificial limbs, braces, and other appliances that are needed daily.

"Eating" means the process of putting food and fluids by any means into the digestive system.

"Elderly" means an applicant or member who is age 65 or older.

"Emotional and cognitive functioning" means an applicant's or member's orientation and mental state, as evidenced by overt behavior.

"EPD" means an applicant or member who is elderly and physically disabled.

"Grooming" means the applicant's or member's process of tending to appearance. Grooming includes: combing or brushing hair, washing face and hands, shaving, performing routine nail care, oral hygiene (including denture care), and menstrual care. Grooming does not include aesthetics such as styling hair, skin care, and applying cosmetics.

"Mobility" means the extent of an applicant's or member's purposeful movement within a residential environment.

"Orientation" means an applicant's or member's awareness of self in relation to person, place, and time.

"Physically disabled" means an applicant or member who is determined physically impaired by the Administration through the PAS assessment as allowed under the Administration's Section 1115 Waiver with CMS.

"Self-injurious behavior" means repeated self-induced, abusive behavior that is directed toward infliction of immediate physical harm to the body.

"Sensory" means of or relating to the senses.

"Suicidal behavior" means an act or intent to take one's life voluntarily.

"Transferring" means an applicant's or member's ability to move horizontally or vertically between two surfaces within a residential environment, excluding transfer for toileting or bathing.

"Wandering" means applicant's or member's moving about with no rational purpose and with a tendency to go beyond the physical parameter of the environment.

C. DD. In addition to definitions contained in subsection (A), the following also applies to an applicant or member who is DD:

"Aggression" means physically attacking another, including:

Throwing objects,

Punching,

Biting,

Pushing,

Pinching,

Pulling hair, and

Scratching.

"Ambulation" means the ability to walk and includes quality of the walking and the degree of independence in walking.

"Associating time with an event and an action" means an applicant's or member's ability to associate a regular event with a specific time-frame.

"Bathing or showering" means an applicant's or member's ability to complete the bathing process including drawing the bath water, washing, rinsing, and drying all parts of the body, and washing the hair.

"Caregiver training" means a direct-care staff person or caregiver trained in special health care procedures normally performed or monitored by a licensed professional, such as a registered nurse. These procedures include ostomy care, positioning for medical necessity, use of an adaptive device or respiratory services such as suctioning or a small volume nebulizer treatment.

"Clarity of communication" means an ability to speak in recognizable language or use a formal symbolic substitution, such as American-Sign Language.

"Climbing stairs or a ramp" means an applicant's or member's ability to move up and down stairs or a ramp.

"Community mobility" means the applicant's or member's ability to move about a neighborhood or community independently, by any mode of transportation.

"Crawling and standing" means an applicant's or member's ability to crawl and stand with or without support.

"DD" means developmentally disabled.

"Developmental milestone" means a measure of an applicant's or member's functional abilities including:

Fine and gross motor skills,

Expressive and receptive language,

Social skills,

Self-help skills, and

Emotional or affective development.

"Dressing" means the ability to put on and remove an article of clothing and does not include braces nor does it reflect an applicant's or member's ability to match colors or choose clothing appropriate for the weather.

"Eating or drinking" means the process of putting food and fluid by any means into the digestive system.

"Expressive verbal communication" means an applicant's or member's ability to communicate thoughts with words or sounds.

"Food preparation" means the ability to prepare a simple meal including a sandwich, cereal, or a frozen meal.

"Hand use" means the applicant's or member's ability to use the hands, or hand if an applicant or member has only one hand, or has the use of only one hand.

"Limited or occasional" means a small portion of an entire task or assistance for the task required less than daily.

"Personal hygiene" means the process of tending to one's appearance. Personal hygiene may include: combing or brushing hair, washing face and hands, shaving, performing routine nail care, oral hygiene including denture care, and menstrual care. This does not include aesthetics such as styling hair, skin care, and applying cosmetics.

"Physical interruption" means immediate hands-on interaction to stop a behavior.

"Remembering an instruction and demonstration" means an applicant's or member's ability to recall an instruction or demonstration on how to complete a specific task.

"Resistiveness or rebelliousness" means an applicant's or member's inappropriate, stubborn, or uncooperative behavior. Resistiveness or rebelliousness does not include an applicant's or member's difficulty with processing information or reasonable expression of self-advocacy that includes an applicant's or member's expression of wants and needs.

"Rolling and sitting" means an applicant's or member's ability to roll and sit independently or with the physical support of another person or with a device such as a pillow or specially-designed chair.

"Running or wandering away" means an applicant or member leaving a physical environment without notifying or receiving permission from the appropriate individuals.

"Self-injurious behavior" means an applicant's or member's repeated behavior that causes injury to the applicant or member.

"Verbal or physical threatening" means any behavior in which an applicant or member uses words, sounds, or action to threaten harm to self, others, or an object.

"Wheelchair mobility" means an applicant's or member's mobility using a wheelchair and does not include the ability to transfer to the wheelchair.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended subsection (C) effective June 6, 1989 (Supp. 89-2). Amended effective July 13, 1992 (Supp. 92-3). Amended effective November 5, 1993 (Supp. 93-4). Section repealed by emergency action, new Section adopted by emergency action, subsection (A) effective June 30, 1995, subsection (B) effective September 1, 1995, pursuant to A.R.S. § 41-1026, valid for 180 days; entire Section filed in the Secretary of State's Office June 30, 1995 (Supp. 95-2). Section repealed by emergency action, new Section adopted again by emergency action with changes effective January 2, 1996, pursuant to A.R.S. § 41-1026, valid for 180 days (Supp. 96-1). Emergency expired June 1, 1996. Section in effect before emergency action restored. Section repealed; new Section adopted effective January 14, 1997 (Supp. 97-1). Amended by final rulemaking at 7 A.A.R. 5824, effective December 7, 2001 (Supp. 01-4).

R9-28-302. General Provisions

To qualify for services described in A.R.S. § 36-2939:

1. An applicant shall meet the financial criteria described in Article 4, and
2. AHCCCS shall determine that the applicant is at immediate risk of institutionalization under the PAS assessment as specified in this Article.

Historical Note

New Section adopted by emergency action, subsection (A) effective June 30, 1995, subsection (B) effective September 1, 1995, pursuant to A.R.S. § 41-1026, valid for 180 days; entire Section filed in the Office of the Secretary of State June 30, 1995 (Supp. 95-2). New Section adopted again by emergency action with changes effective January 2, 1996, pursuant to A.R.S. § 41-1026 (Supp. 96-1). Emergency expired June 1, 1996. New Section adopted effective January 14, 1997 (Supp. 97-1). Amended by final rulemaking at 7 A.A.R. 5824, effective December 7, 2001 (Supp. 01-4).

R9-28-303. Preadmission Screening (PAS) Process

A. An assessor shall complete the PAS instrument as part of the initial assessment or reassessment for:

1. An applicant or member who is DD or EPD,
2. A hospitalized applicant, or
3. An applicant or member who is ventilator dependent.

B. The assessor shall use the PAS instrument to assess whether the following applicants are at immediate risk of institutionalization:
1. The assessor shall use the PAS instrument prescribed in R9-28-304 to assess an applicant or member who is EPD except a physically disabled applicant or member who is less than 6 years old.
2. The assessor shall use the age-specific PAS instrument prescribed in R9-28-305 for an applicant or member who is physically disabled or less than 6 years old. After assessing the child in subsection (1), the assessor shall refer the child for physician consultant review under R9-28-303.
3. The assessor shall use the PAS instrument prescribed in R9-28-305 to assess an applicant or member who is DD, except an applicant or member who is:
   a. DD and residing in a NF. The assessor shall use the PAS instrument prescribed in R9-28-304; or
   b. DD or physically disabled and less than 6 months of age. The assessor shall use the PAS instrument prescribed in R9-28-305. After assessing the child, the assessor shall refer the child for physician consultant review under R9-28-303.

C. For an applicant or member who is ventilator dependent, a registered nurse assessor shall complete the PAS instrument, and determine an applicant or member at immediate risk of institutionalization when the applicant or member is classified as ventilator-dependent, under Section 1902(e)(9) of the Social Security Act, January 1, 1995, incorporated by reference and on file with the Administration and the Office of the Secretary of State, This incorporation by reference contains no future editions or amendments.

D. For an initial assessment of an applicant who is in a hospital or other acute care setting:
1. A registered nurse assessor shall complete the PAS instrument, or
2. In the event that a registered nurse assessor is not available, a social worker assessor shall complete the PAS assessment; and
3. The assessor shall conduct the PAS assessment and determine medical eligibility when discharge is scheduled within seven days.

E. An assessor shall conduct a face-to-face PAS assessment with an applicant or member, except as provided in subsection (H). The assessor shall make reasonable efforts to obtain the applicant's or member's available medical records. The assessor may also obtain information for the PAS assessment from face-to-face interviews with the:
1. Applicant or member,
2. Parent,
3. Guardian,
4. Caregiver, or
5. Any person familiar with the applicant's or member's functional or medical condition.

F. Using the information described in subsection (E), an assessor shall complete the PAS instrument based on education, experience, professional judgment, and training as described in R9-28-301(A).

G. After the assessor completes the PAS instrument, the assessor shall calculate a PAS score. The assessor shall compare the PAS score to an established threshold score. The scoring methodology and threshold scores are specified in R9-28-304 and R9-28-305. Except as determined by physician consultant review as provided in subsections (I) and (J), the threshold score is the point at which an applicant or member is determined at immediate risk of institutionalization.

H. Upon request, the Administration shall conduct a PAS assessment to determine whether a deceased applicant who was in a NF or ICF-MR any time during the months covered by the application would have been eligible to receive ALTCS benefits for those months.

I. The Administration shall request that an AHCCCS physician consultant review the PAS instrument, available medical records, and professional judgement when:
1. The PAS score of an applicant or member who is EPD is less than the threshold specified in R9-28-304, but is at least 56;
2. The PAS score of an applicant or member who is DD is less than the threshold specified in R9-28-305, but is at least 38;
3. An applicant or member scores below the threshold specified in R9-28-304, but the Administration has reasonable cause to believe that the applicant's or member's unique functional abilities or medical condition places the applicant or member at immediate risk of institutionalization;
4. An applicant or member scores below the threshold specified in R9-28-304 and has a documented diagnosis of autism, autistic-like behavior or pervasive developmental disorder; or
5. An applicant or member who is seriously mentally ill as defined in A.R.S. § 36-550 and achieves a score at or above the threshold specified in R9-28-304, but does not meet the requirements of A.R.S. § 36-2936. Despite a score at or above the threshold, the physician consultant exercises professional judgement and determines if the applicant or member meets the requirements of A.R.S. § 36-2936.

J. The physician conducting the review shall use the information contained in the PAS instrument, available medical records, and professional judgement to determine whether an applicant or member is DD or has a nonpsychiatric medical condition that, by itself or in combination with a medical condition, places an applicant or member at immediate risk of institutionalization. At a minimum, the physician shall consider the following:
1. ADL dependence;
2. Delay in development;
3. Continence;
4. Orientation;
5. Behavior;
6. Any medical condition, including stability and prognosis;
7. Any medical nursing treatment including skilled monitoring, medication, and therapeutic regimens;
8. Supervision requirements;
9. Caregiver skill and training requirements; and
10. Any factor of significance to the individual case.

K. The physician shall state the reasons for the recommended decision in the comment section of the PAS instrument.

L. If the physician is unable to determine eligibility from the PAS instrument and available medical records, the physician may conduct a face-to-face review with the applicant or member or contact others familiar with the applicant's or member's needs, including primary care physician or other caregiver.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective July 13, 1992 (Supp. 92-3). Amended under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61, effective July 1, 1993 (Supp. 93-3). Amended effective November 5, 1993 (Supp. 93-4). Section repealed by emergency action, new Section adopted by emergency action effective June 30, 1995, pursuant to A.R.S. § 41-

1026, valid for 180 days (Supp. 95-2). Section repealed by emergency action, new Section adopted again by emergency action effective January 2, 1996, pursuant to A.R.S. § 41-1026, valid for 180 days (Supp. 96-1). Emergency expired June 1, 1996. Section in effect before emergency action restored. Section repealed; new Section adopted effective January 14, 1997 (Supp. 97-1). Former Section R9-28-303 renumbered to R9-28-304; new Section R9-28-303 made by final rulemaking at 7 A.A.R. 5824, effective December 7, 2001 (Supp. 01-4).

R9-28-304. Preadmission Screening Criteria for an Applicant or Member who is Elderly and Physically Disabled (EPD)

A. The PAS instrument for an applicant or member who is EPD includes four major categories:
1. Intake information category. The assessor solicits intake information category information on an applicant's or member's demographic background. The components of the intake information category are not included in the calculated PAS score.
2. Functional assessment category. The assessor solicits functional assessment category information on an applicant's or member's:
   a. Need for assistance with activities of daily living, including:
      i. Bathing,
      ii. Dressing,
      iii. Grooming,
      iv. Eating,
      v. Mobility,
      vi. Transferring, and
      vii. Toileting in the residential environment or other routine setting;
   b. Communication and sensory skills, including hearing, expressive communication, and vision; and
   c. Continence, including bowel and bladder functioning.
3. Emotional and cognitive functioning category. The assessor solicits emotional and cognitive functioning category information on an applicant's or member's:
   a. Orientation to person, place, and time; and
   b. Behavior, including:
      i. Wandering,
      ii. Self-injurious behavior,
      iii. Aggression,
      iv. Suicidal behavior, and
      v. Disruptive behavior.
4. Medical assessment category. The assessor solicits medical assessment category information on an applicant's or member's:
   a. Medical condition and the medical condition's impact on the applicant's or member's ability to perform independently activities of daily living;
   b. Medical condition that requires medical or nursing service and treatment;
   c. Medication, treatment, and allergies;
   d. Specific services and treatments that the applicant or member receives or needs and the frequency of the services and treatments; and
   e. Physical measurements, hospitalization history, and ventilator dependency.

B. The assessor shall use the PAS instrument to assess an applicant or member who is EPD. A copy of the PAS instrument is available from the Administration. The Administration uses the assessor's PAS instrument responses to calculate three scores: a functional score, a medical score, and a total score.
1. Functional score.
   a. The Administration calculates the functional score from responses to scored items in the functional assessment and emotional and cognitive functioning categories. For each response to a scored item, a number of points is assigned, which is multiplied by a weighted numerical value. The result is a weighted score for each response.
   b. Designated items in the categories are scored according to subsection (C), under the following assessment matrices:
      i. Sensory skills;
      ii. Medical conditions; and
      iii. Medical or nursing service and treatment.
   c. All items in the following categories are scored, according to subsection (C), under the Functional Assessment matrix:
      i. Activities of daily living;
      ii. Continence;
      iii. Orientation; and
      iv. Behavior.
   d. The sum of the weighted scores equals the functional score. The weighted score per item can range from 0 to 15. The maximum functional score attainable by an applicant or member is 141. No minimum functional score is required except as prescribed in subsections (B)(3)(c) and (B)(3)(d).
2. Medical score.
   a. The EPD population is divided into two groups for purposes of calculating the medical score. The primary distinction between the two groups is the difference in medical need as follows:
      i. Group 1 includes an applicant or member diagnosed with paralysis, head trauma, multiple sclerosis, amyotrophic lateral sclerosis, or Parkinson's disease that either impacts the applicant's or member's ability to perform activities of daily living independently or requires the applicant or member to receive nursing services or treatments.
      ii. Group 2 includes an applicant or member diagnosed with Alzheimer's disease, dementia, or an organic brain syndrome that either impacts the applicant's or member's ability to perform activities of daily living independently or requires medical or nursing services and treatments. If an applicant or member does not meet one of the criteria for Group 2, the applicant or member is considered to be in Group 1.
   b. Scoring methodology: Group 1 individuals.
      i. The Administration calculates the medical score is from responses to scored items in the medical conditions and the services and treatments sections of the PAS instrument.
      ii. Each response to a scored item in the medical assessment category is assigned a certain number of points, ranging from 0 to 4 points per item.
      iii. The sum of the points equals the medical score, with a maximum score of 63. No minimum medical score is required, except as prescribed in subsection (B)(3)(c).
   c. Scoring Methodology: Group 2 individuals.
      i. The Administration calculates the medical score from responses to scored items in the services and treatments section of the PAS instrument.

ii. Each response to a scored item in the medical assessment category is assigned a number of points, ranging from 0 to 16 points per item.
iii. The sum of the points equals the medical score, with a maximum score of 42. No minimum medical score is required, except as prescribed in subsection (B)(3)(d).

3. Total score.
   a. The sum of an applicant's or member's functional and medical scores equals the total score.
   b. The total score is compared to an established threshold score in R9-28-304 calculated under R9-31-304. Regardless of whether an applicant or member is in Group 1 or in Group 2, the threshold score is 60.
   c. Except as defined in R9-28-303, an applicant is determined at immediate risk of institutionalization if one of the following is met:
      i. The applicant or member has a total score equal to or greater than 60;
      ii. The applicant or member in Group 1 has a total score less than 60, a functional score equal to or greater than 30, and a medical score equal to or greater than 13;
      iii. The applicant or member in Group 2 has a total score less than 60 and a functional score equal to or greater than 30, and a weighted score from the orientation section equal to or greater than 5; or
      iv. The applicant or member in Group 2 has a total score equal to or greater than 30 and is assigned at least two points for any one item in the behavior section.

C. The following matrices represent the number of points available and the respective weight for each scored item.
1. Functional assessment points. The lowest value in the range of points available per item in the functional assessment category indicates minimal to no impairment. Conversely, the highest value indicates severe impairment.
2. Medical assessment points. The lowest value in the range of points available per item in the medical assessment category, 0, indicates that the applicant or member:
   a. Does not have a medical condition,
   b. Does not need medical or nursing services, or
   c. Does not receive any medical or nursing services.

FUNCTIONAL ASSESSMENT	**# of Points Available Per Item 1 (P)**	**Weight (W)**	**Range of Possible Weighted Score per Item (P)x(W)**
Activities of Daily Living Section			
Bathing, Dressing, Grooming, Mobility, Toileting	0-5	3	0-15
Eating	0-6	2.5	0-15
Transfer	0-4	3.75	0-15
Continence Section			
Bowel	0-2	0	0
	3	.167	.5
Bladder	0-4	0.5	0-2
Sensory Section			
	0-1	0	0
Vision	2	1.75	3.5
	3	1.167	3.5
Orientation Section			
Person, Place, Time	0-3	1	0-3
Emotional or Cognitive Behavior Section			
Aggression, Self-injurious, Suicidal, Wandering	0-3	1	0-3
Disruptive	0-3	3	0-9

MEDICAL ASSESSMENT **GROUP 1**	**# of Points Available Per Item 1 (P)**	**Weight (W)**	**Range of Possible Weighted Score Per Item (P)x(W)**
Medical Conditions Section			
Paralysis or Sclerosis	0-1	3	0 - 3
Alzheimer's, or OBS, or Dementia	0-1	3.5	0 - 3.5

Services and Treatments Section			
Physical Therapy, Occupational Therapy, Speech Therapy	0-1	0.5	0 - .5
Suctioning, Oxygen, Small Volume Nebulizer, Tracheostomy Care, Postural Drainage, Respiratory Therapy	0-1	1.5	0 or 1.5
Drug Regulation	0-1	2	0 or 2
Decubitus Care, Wound Care, Ostomy Care, Feedings-Tube or Parenteral, Catheter Care, Other Ostomy Care, Dialysis, Fluid Intake or Output	0-1	3	0 or 3
Teaching or Training Program, Bowel or Bladder Program, Range of Motion, Other Rehabilitative Nursing, Restraints	0-1	4	0 or 4

MEDICAL ASSESSMENT **GROUP 2**	**# of Points Available per Item (P)**	**Weight (W)**	**Range of Possible Weighted Score Per Item**
Drug Regulation	0-1	2	0 or 2
Teaching or Training Program, Bowel or Bladder Program, Range of Motion, Other Rehabilitative Nursing	0-1	6	0 or 6
Restraints (Physical or Chemical)	0-1	16	0 or 16

Historical Note

New Section adopted by emergency action, subsection (A) effective June 30, 1995, subsection (B) effective September 1, 1995, pursuant to A.R.S. § 41-1026, valid for 180 days; entire Section filed as an emergency rule with the Secretary of State's Office June 30, 1995 (Supp. 95-2). New Section adopted again by emergency action with changes effective January 2, 1996, pursuant to A.R.S. § 41-1026, valid for 180 days (Supp. 96-1). Emergency expired. New Section adopted effective January 14, 1997 (Supp. 97-1). Former Section R9-28-304 renumbered to R9-28-305; new Section R9-28-304 renumbered from R9-28-303 and amended by final rulemaking at 7 A.A.R. 5824, effective December 7, 2001 (Supp. 01-4).

R9-28-305. Preadmission Screening Criteria for an Applicant or Member who is Developmentally Disabled (DD)

A. The Administration shall conduct a PAS assessment of an applicant or member who is DD using one of four PAS instruments specifically designed to assess an applicant or member in the following age groups:
1. 12 years of age and older,
2. 6 to 11 years of age,
3. 3 to 5 years of age, and
4. Less than 3 years of age.

B. The PAS instruments for an applicant or member who is DD include three major categories:
1. Intake information category. The assessor solicits intake information category information on an applicant's or member's demographic background. The components of this category are not included in the calculated PAS score.
2. Functional assessment category. The functional assessment category differs by age group as indicated in subsections (B)(2)(a) through (B)(2)(e):
   a. For an applicant or member 12 years of age and older, the assessor solicits the functional assessment category information on an applicant's or member's:
      i. Need for assistance with independent living skills, including hand use, ambulation, wheelchair mobility, transfer, eating or drinking, dressing, personal hygiene, bathing or showering, food preparation, community mobility, and toileting;
      ii. Communication skills and cognitive abilities, including expressive verbal communication, clarity of communication, associating time with an event and action, and remembering an instruction and a demonstration; and
      iii. Behavior, including aggression, verbal or physical threatening, self-injurious behavior, and resistive or rebellious behavior.
   b. For an applicant or member 6 through 11 years of age, the assessor solicits the functional assessment category information on an applicant's or member's:
      i. Need for assistance with independent living skills, including rolling and sitting, crawling and standing, ambulation, climbing stairs or ramps, wheelchair mobility, dressing, personal hygiene, bathing or showering, toileting, level of bladder control, and orientation to familiar settings;
      ii. Communication, including expressive verbal communication and clarity of communication; and
      iii. Behavior, including aggression, verbal or physical threatening, self-injurious behavior, run-

ning or wandering away, and disruptive behavior.

c. For an applicant or member 3 through 5 years of age, the assessor solicits the functional assessment category information on an applicant's or member's:
   i. Performance with respect to a series of developmental milestones that measure an applicant's or member's degree of functional growth;
   ii. Need for assistance with independent living skills, including toileting and dressing, and an applicant's or member's orientation to familiar settings;
   iii. Communication, including clarity of communication; and
   iv. Behavior, including aggression, verbal or physical threatening, and self-injurious behavior.

d. For an applicant or member 6 months of age through 3 years of age, the assessor solicits the functional assessment category information on age-specific developmental milestones.

e. For an applicant or member less than 6 months of age, the assessor shall not complete a functional assessment. The assessor shall include a description of the applicant's or member's development in the PAS instrument narrative summary.

3. Medical assessment category. The assessor solicits medical assessment category information on an applicant's or member's:
   a. Medical condition;
   b. Specific services and treatments the applicant or member receives or needs and the frequency of those services and treatments;
   c. Current medication;
   d. Medical stability;
   e. Sensory functioning;
   f. Physical measurements; and
   g. Current placement, ventilator dependency and eligibility for DES Division of Developmental Disabilities program services.

C. The assessor shall use the PAS instrument to assess an applicant or member who is DD. A copy of the PAS instrument is available from the Administration. The Administration uses the assessor's PAS instrument responses to calculate three scores: a functional score, a medical score, and a total score.

1. Functional score.
   a. The Administration calculates the functional score from responses to scored items in the functional assessment category. Each response is assigned a scored a number of points which is multiplied by a weighted numerical value, resulting in a weighted score for each response.
   b. The following items are scored as indicated in subsection (D), under the Functional Assessment matrix:
      i. For an applicant or member 12 years of age and older, all items in the behavior section are scored. Designated items in the independent living skills, communication skills, and cognitive abilities sections are also scored;
      ii. For an applicant or member 6 through 11 years of age, all items in the communication section are scored. Designated items in the independent living skills and behavior sections are scored;
      iii. For an applicant or member 3 through 5 years of age, all items in the developmental milestones and behavior section are scored. Designated items in the independent living skills are scored; and
      iv. For an applicant or member 6 months of age up to 3 years of age, all items regarding age specific milestones are scored.
   c. The sum of the weighted scores equals the functional score. The range of weighted score per item and maximum functional score for each age group is presented below:

AGE GROUP	RANGE FOR WEIGHTED SCORE PER ITEM	MAXIMUM FUNCTIONAL SCORE ATTAINABLE
12+	0 - 11.2	124.1
6-11	0 - 24	112.5
3-5	0 - 15.6	78.2
0-2	0 - 1.4	70

   d. No minimum functional score is required.

2. Medical score.
   a. Items (i) through (iii) are scored as indicated in subsection (D), under the Medical Assessment matrix:
      i. The assessor shall score designated items in the medical conditions for an applicant or member 12 years of age and older and 6 years of age through 11 years of age.
      ii. The assessor shall score designated items in the medical conditions and medical stability sections for an applicant or member 3 years of age through 6 years of age.
      iii. The assessor shall score designated items in the medical conditions, services and treatments, and medical stability sections for an applicant or member 6 months of age through 3 years of age.
      iv. The assessor shall complete only the medical assessment section of the PAS for an applicant or member less than 6 months of age. There is no weighted or calculated score assigned. The assessor shall refer the applicant or member for physician consultant review.
   b. The Administration calculates the medical score from information obtained in the medical assessment category. Each response to a scored item is assigned a number of points. The sum of the points equals the medical score. The range of points per item and the maximum medical score attainable by an applicant or member is presented below:

AGE GROUP	RANGE OF POINTS PER ITEM	MAXIMUM MEDICAL SCORE ATTAINABLE
12+	0 - 20.6	21.4
6-11	0 - 2.5	5
3-5	0 - 14.8	23
0-2	0 - 7	44.3

   c. No minimum medical score is required.

3. Total score.
   a. The sum of an applicant's or member's functional and medical scores equals the total score.

b. The total score is compared to an established threshold score in R9-28-304. For an applicant or member who is DD, the threshold score is 40. Based upon the PAS instrument an applicant or member with a total score equal to or greater than 40 is at immediate risk of institutionalization.

D. The following matrices represent the number of points available and the weight for each scored item.

1. Functional assessment points. The lowest value in the range of points available per item in the functional assessment category indicates minimal to no impairment. Conversely, the highest value indicates severe impairment.
2. Medical assessment points. The lowest value in the range of points available per item in the medical assessment category, 0, indicates that the applicant or member:
   a. Does not have a medical condition,
   b. Does not need medical or nursing services, or
   c. Does not receive any medical or nursing services.

AGE GROUP 12 AND OLDER FUNCTIONAL ASSESSMENT	**# of Points Available Per Item (P)**	**Weight (W)**	**Range of Possible Weighted Score Per Item (P) x (W)**
Independent Living Skills Section			
Hand Use, Food Preparation	0-3	3.5	0-10.5
Ambulation, Toileting, Eating, Dressing, Personal Hygiene	0-4	2.8	0-11.2
Communicative Skills and Cognitive Abilities Section			
Associating Time, Remembering Instructions	0-3	0.5	0 - 1.5
Behavior Section			
Aggression, Threatening, Self Injurious	0-4	2.8	0-11.2
Resistive	0-3	3.5	0-10.5

AGE GROUP 12 AND OLDER MEDICAL ASSESSMENT	**# of Points Available Per Item (P)**	**Weight (W)**	**Range of Possible Weighted Score Per Item (P) x (W)**
Medical Conditions Section			
Cerebral Palsy, Epilepsy	0-1	0.4	0-.4
Moderate, Severe, Profound Mental Retardation	0-1	20.6	0-20.6

AGE GROUP 6-11 FUNCTIONAL ASSESSMENT	**# of Points Available Per Item (P)**	**Weight (W)**	**Range of Possible Weighted Score Per Item (P) x (W)**
Independent Living Skills Section			
Climbing Stairs, Wheelchair Mobility, Bladder Control	0-3	1.875	0-5.625
Ambulation, Dressing, Bathing, Toileting	0-4	1.5	0-6
Crawling or Standing	0-5	1.25	0-6.25
Rolling or Sitting	0-8	0.833	0-6.66
Communication Section			
Clarity	0-4	1.5	0-6
Expressive Communication	0-5	1.25	0-6.25
Behavior Section			
Wandering	0-4	6	0-24
Disruptive	0-3	7.5	0-22.5

AGE GROUP 6 - 11 MEDICAL ASSESSMENT	**# of Points Available Per Item (P)**	**Weight (W)**	**Range of Possible Weighted Score Per Item (P) x (W)**
Medical Conditions Section			
Cerebral Palsy, Epilepsy	0-1	2.50	0-2.5

AGE GROUP 3-5 FUNCTIONAL ASSESSMENT	**# of Points Available Per Item (P)**	**Weight (W)**	**Range of Possible Weighted Score Per Item (P) x (W)**
Developmental Milestones Section			
Factors Measuring an Individual's Degree of Functional Growth	0-1	0.70	0-.7
Independent Living Skills Section			
Toileting, Dressing	0-4	3.90	0-15.6
Behavior Section			
Aggression, Threatening, Self Injurious	0-4	1.00	0-4

AGE GROUP 3 - 5 MEDICAL ASSESSMENT	**# of Points Available Per Item (P)**	**Weight (W)**	**Range of Possible Weighted Score Per Item (P) x (W)**
Medical Conditions Section			
Moderate, Severe, Profound Mental Retardation	0-1	14.80	0-14.8
Medical Stability Section			
Direct Caregiver Required, Special Diet	0-1	4.10	0-4.1

AGE GROUP 0-2 FUNCTIONAL ASSESSMENT	**# of Points Available Per Item (P)**	**Weight (W)**	**Range of Possible Weighted Score Per Item (P) x (W)**
Developmental Milestones Section			
Factors Measuring an Individual's Degree of Functional Growth	0-1	1.40	0-1.4

AGE GROUP 0-2 MEDICAL ASSESSMENT	**# of Points Available Per Item**	**Weight**	**Range of Possible Weighted Score Per Item (P) x (W)**
Services and Treatments Section			
Non-Bladder or Bowel Ostomy, Tube Feeding, Oxygen	0-1	6.10	0-6.1
Medical Conditions Section			
Any Mental Retardation, Epilepsy, Cerebral Palsy	0-1	7.00	0-7
Medical Stability Section			
Services and Treatments Section			
Trained Direct Caregiver, Special Diet or a Minimum of 2 Hospitalizations	0-1	5.00	0-5

Historical Note

Section adopted by emergency action effective June 30, 1995, pursuant to A.R.S. § 41-1026, valid for 180 days (Supp. 95-2). Section adopted again by emergency action effective January 2, 1996, pursuant to A.R.S. § 41-1026, valid for 180 days (Supp. 96-1). Emergency expired. New Section adopted effective January 14, 1997 (Supp. 97-1). Former Section R9-28-305 renumbered to R9-28-306; new Section R9-28-305 renumbered from R9-28-304 and amended by final rulemaking at 7 A.A.R. 5824, effective December 7, 2001 (Supp. 01-4).

R9-28-306. Reassessments

A. An assessor shall reassess an ALTCS member to determine continued eligibility:
1. In connection with a routine audit of the PAS assessment by AHCCCS;
2. In connection with a request by a provider, program contractor, case manager, or other party, if AHCCCS determines that continued eligibility is uncertain due to substantial evidence of a change in the member's circumstances or error in the PAS assessment; or
3. Annually when part of a population group identified by the Director in a written report as having an increased likelihood of becoming ineligible.

B. An assessor shall determine continued eligibility for ALTCS using the same criteria used for the initial PAS assessment as prescribed in R9-28-303.

C. An assessor shall refer the reassessment to physician consultant review if the member is:
1. Determined ineligible,
2. In the ALTCS Transitional Program under R9-28-307 and resides in a NF or ICF-MR, or
3. Seriously mentally ill and no longer has a non-psychiatric medical condition that impacts the member's ability to function.

Historical Note

Adopted effective September 1, 1995, under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1994, Ch. 322, § 21; filed with the Office of the Secretary of State June 29, 1995 (Supp. 95-3). Former Section R9-28-306 renumbered to R9-28-307; new Section R9-28-306 renumbered from R9-28-305 and amended by final rulemaking at 7 A.A.R. 5824, effective December 7, 2001 (Supp. 01-4). Amended by final rulemaking at 10 A.A.R. 1312, effective May 1, 2004 (Supp. 04-1).

R9-28-307. Transitional Program for a Member who is Elderly and Physically Disabled (EPD) or Developmentally Disabled (DD)

A. The ALTCS transitional program serves members enrolled in the ALTCS program who, at the time of reassessment as described in R9-28-306, no longer meet the threshold specified in R9-28-304 for EPD or in R9-28-305 for DD. The member must meet all other ALTCS eligibility criteria. The member's PAS assessment will be compared to a second scoring methodology for eligibility in the transitional program as defined in subsections (B) and (C).

B. The Administration shall transfer a member who is DD from the ALTCS program to the ALTCS transitional program if, at the time of a reassessment, the total PAS score is less than the threshold described in R9-28-305 but is at least 30, or the member is diagnosed with moderate, severe, or profound mental retardation.

C. The Administration shall transfer a member who is EPD from the ALTCS program to the ALTCS transitional program if, at the time of a reassessment, the PAS score is less than the threshold described in R9-28-304 but the member meets one or more of the following criteria:
1. Has a score of two or more on three of the following activities for daily living:
   a. Eating,
   b. Dressing,
   c. Bathing,
   d. Toileting, and
   e. Transferring;
2. Has a diagnosis of:
   a. Alzheimer's disease,
   b. Organic brain syndrome,
   c. Dementia,
   d. Parkinson's disease, or
   e. Head trauma that impacts activities of daily living; and
3. Has a score of two or more on any of the items in the emotional and cognitive functioning category.

D. An assessor shall conduct a reassessment annually of a member qualifying for the transitional program to determine if the member continues to meet the criteria specified in subsections (B) and (C).

E. For a member residing in a NF or ICF-MR, the program contractor or the Administration has up to 90 continuous days from the enrollment date of the member's eligibility for the transitional program to move the member to an approved home- and community-based setting.

F. A member in the transitional program shall continue to receive all medically necessary covered services as specified in Article 2.

G. The member is eligible to receive up to 90 continuous days per NF or ICF-MR admission when the member's condition worsens to the extent that an admission is medically necessary.

H. For a member requiring medically necessary NF or ICF-MR services for longer than 90 days, the program contractor shall request the Administration to conduct a reassessment.

Historical Note

New Section renumbered from R9-28-306 and amended by final rulemaking at 7 A.A.R. 5824, effective December 7, 2001 (Supp. 01-4).

ARTICLE 4. ELIGIBILITY AND ENROLLMENT

R9-28-401. General

A. Application for ALTCS coverage.
1. The Administration shall provide a person the opportunity to apply for ALTCS without delay.
2. A person may be accompanied, assisted, or represented by another in the application process.
3. To apply for ALTCS, a person shall submit a written application to an ALTCS eligibility office.
   a. The application shall contain the applicant's name and address.
   b. A person listed in A.A.C. R9-22-1405(B) shall submit the application.
   c. Before the application is approved a person listed in A.A.C. R9-22-1405(E) shall sign the application.
   d. A witness shall also sign the application if an applicant signs the application with a mark.
   e. The date of application is the date the application is received at any ALTCS eligibility office.
4. Except as provided in R9-22-1501(C)(5), the Administration shall determine eligibility within 45 days from the date of application.
5. An applicant or representative who files an ALTCS application may withdraw the application for ALTCS coverage either orally or in writing to the ALTCS eligibility office where the application was filed. The Administration shall provide the applicant with a denial notice under subsection (G).
6. If an applicant dies while an application is pending, the Administration shall complete an eligibility determination for the deceased applicant.
7. The Administration shall complete an eligibility determination on an application filed on behalf of a deceased applicant, if the application is filed in the month of the person's death.

B. Conditions of ALTCS eligibility. Except for persons identified in subsection (C), the Administration shall approve a person for ALTCS if all conditions of eligibility for one of the ALTCS coverage groups listed in R9-28-402(B) are met. The conditions of eligibility are:
1. Categorical requirements under R9-28-402;
2. Citizenship and alien status under R9-28-404;
3. SSN under R9-28-405;
4. Living arrangements under R9-28-406;
5. Resources under R9-28-407;
6. Income under R9-28-408;
7. Transfers under R9-28-409;
8. A legally authorized person shall assign rights to the Administration for medical support and for payment of medical care from any first- and third-parties and shall cooperate by:
   a. Obtaining medical support and payments and establishing paternity for a child born out of wedlock, except for pregnant women under A.A.C. R9-22-1421, unless the person establishes good cause under 42 CFR 433.147 for not cooperating; and
   b. Identifying and providing information to assist the Administration in pursuing first-and third-parties who may be liable to pay for care and services unless the person establishes good cause for not cooperating;
9. A person shall take all necessary steps to obtain annuity, pension, retirement, and disability benefits for which a person may be entitled unless the person establishes good cause for not doing so;
10. State residency under R9-28-403;
11. Medical eligibility specified in Article 3 of this Chapter; and
12. Providing information and verification specified in Section (D).

C. Persons eligible for Title IV-E or Title XVI. To be determined eligible for ALTCS, a person eligible for benefits under Title IV-E or Title XVI of the Social Security Act shall provide information to allow the Administration to determine:
1. Medical eligibility specified in Article 3 of this Chapter;
2. Post-eligibility treatment of income specified in R9-28-408;
3. Trusts in accordance with federal and state law; and
4. Transfer of property specified in R9-28-409.

D. Verification. If requested by the Administration, a person shall provide information and documentation to verify the following criteria or shall authorize the Administration to verify the following criteria:
1. Categorical requirements under R9-28-402,
2. SSN under R9-28-405,
3. Living arrangements under R9-28-406,
4. Resources under R9-28-407,
5. Transfers of assets under R9-28-409,
6. Income under R9-28-408,
7. Citizenship and alien status under R9-28-404,
8. First- and third-party liability under subsection (B)(8),
9. Application for potential benefits under subsection (B)(9),
10. State residency under R9-28-403,
11. Medical conditions under Article 3 of this Chapter, and
12. Other individual circumstances necessary to determine a person's eligibility and post-eligibility treatment of income (share-of-cost).

E. Documentation of the eligibility decision. The ALTCS eligibility interviewer shall include facts in a person's case record to support the decision on the person's application.

F. Eligibility effective date. Eligibility is effective the first day of the month that all eligibility requirements are met but no earlier than the month of application.

G. Notice. The Administration shall send a person a written notice of the decision regarding the person's application. The notice shall include a statement of the action and an explanation of the person's hearing rights specified in Article 8 of this Chapter and:
1. If the applicant's eligibility is approved, the notice shall contain:
   a. The effective date of eligibility; and
   b. Post-eligibility treatment of income (share-of-cost) information, which is the amount the person shall pay toward the cost of care.
2. If the applicant's eligibility is denied, the notice shall contain:
   a. The effective date of the denial;
   b. A statement detailing the reason for the person's denial, including specific financial calculations and the financial eligibility standard if applicable; and
   c. The legal authority supporting the decision.

H. Confidentiality. The Administration shall maintain the confidentiality of a person's record and shall not disclose the person's financial, medical, or other privacy interests except under A.A.C. R9-22-512.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective June 6, 1989 (Supp. 89-2). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 369, effective January 6, 1999 (Supp. 99-1). Amended by exempt rulemaking at 7 A.A.R. 4691, effective October 1, 2001 (Supp. 01-3). Amended by final rulemaking at 9 A.A.R. 5138, effective January 3, 2004 (Supp. 03-4).

R9-28-402. Categorical Requirements and Coverage Groups

A. Categorical requirements. As a condition of ALTCS eligibility, a person shall meet one of the following categorical requirements in this Section under 42 CFR 435, Subpart F.
1. Aged.
   a. "Aged" means a person who is 65 years of age or older.
   b. A person is considered to be age 65 on the day before the anniversary of birth.
   c. Age shall be verified under 20 CFR 404.715 and 20 CFR 404.716.
2. Blind. Blindness shall be determined by the DES Disability Determination Services Administration, under 42 U.S.C. 1382c(a)(2).
3. Disabled. A person is considered to be disabled for ALTCS if the person is determined medically eligible under Article 3.
4. Child. A child is a person defined in A.A.C. R9-22-1420.
5. Pregnant.
   a. Pregnancy shall be medically verified by one of the following licensed health care professionals:
      i. Licensed physician;
      ii. Certified physician's assistant;
      iii. Certified nurse practitioner;
      iv. Licensed midwife; or
      v. Licensed registered nurse, under the direction of a licensed physician.
   b. Written verification of pregnancy shall include the expected date of delivery.
6. A specified relative who is the caretaker relative of a deprived child under Section 2 of the AFDC State Plan as

it existed on July 16, 1996, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.

B. ALTCS coverage groups. In addition to other requirements in this Article, a person shall meet ALTCS eligibility criteria in one of the following coverage groups:
1. A coverage group under A.R.S. §§ 36-2901(6)(a)(i) or 36-2901(6)(a)(ii).
2. The 210 coverage group specified in 42 CFR 435.210. A person in the 210 coverage group is medically eligible as specified in Article 3 and would be eligible for SSI cash assistance or meets the criteria for AFDC under Section 2 of the AFDC State Plan as it existed on July 16, 1996.
3. The 236 coverage group under 42 CFR 435.236. A person in the 236 coverage group is medically eligible as specified in Article 3 and the person resides in a medical institution.
4. The 217 coverage group under 42 CFR 435.217. A person in the 217 coverage group is medically eligible as specified in Article 3 and the person resides in a home and community-based setting described in R9-28-406(A)(2).

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective June 6, 1989 (Supp. 89-2). Amended effective July 13, 1992 (Supp. 92-3). Amended effective November 5, 1993 (Supp. 93-4). Repealed effective November 4, 1998 (Supp. 98-4). New Section adopted by final rulemaking at 5 A.A.R. 369, effective January 6, 1999 (Supp. 99-1). Amended by exempt rulemaking at 7 A.A.R. 4691, effective October 1, 2001 (Supp. 01-3).

R9-28-403. State Residency
As a condition of eligibility, a person shall be a resident of Arizona as specified in 42 CFR 435.403, December 21, 1990, incorporated by reference and on file with the Administration and Secretary of State. This incorporation contains no future editions or amendments.

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective April 25, 1990 (Supp. 90-2). Amended effective July 13, 1992 (Supp. 92-3). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 369, effective January 6, 1999 (Supp. 99-1).

R9-28-404. Citizenship and Qualified Alien Status
As a condition of eligibility, a person shall be:
1. A citizen of the United States;
2. A qualified alien specified in 8 U.S.C. 1641 and A.R.S. § 36-2903.03, to the extent consistent with federal law; or
3. A nonqualified alien who received ALTCS services on or before August 21, 1996, as specified in Laws 1997, Ch. 300, § 70.

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective April 25, 1990 (Supp. 90-2). Amended effective July 13, 1992 (Supp. 92-3). Amended effective November 5, 1993 (Supp. 93-4). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 369, effective January 6, 1999 (Supp. 99-1).

R9-28-405. Social Security Enumeration
As a condition of eligibility, a person shall furnish an SSN, as specified in 42 CFR 435.910 and 435.920.

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective June 6, 1989 (Supp. 89-2). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 369, effective January 6, 1999 (Supp. 99-1).

R9-28-406. ALTCS Living Arrangements
A. Long-term care living arrangements. A person may be eligible for ALTCS services, under Article 2, while living in one of the following settings:
1. Institutional settings:
   a. A NF defined in 42 U.S.C. 1396r(a),
   b. An IMD for a person who is either under age 21 or age 65 or older or a person aged 21 through 64 for up to 30 days per admission and no more than 60 days per contract year under the Administration's Section 1115 Waiver with CMS,
   c. An ICF-MR for a person with developmental disabilities,
   d. A hospice (free-standing, hospital, or nursing facility subcontracted beds) defined in A.R.S. § 36-401; or
2. Home and community-based services (HCBS) settings:
   a. A person's home defined in R9-28-101(B), or
   b. Alternative HCBS settings defined in R9-28-101(B).

B. ALTCS acute care living arrangements. A person applying for or receiving ALTCS coverage shall be eligible for only ALTCS acute care coverage in the following living arrangements, settings, or locations:
1. The gross income limit is 300 percent of the FBR for a person meeting the requirements of the 236 coverage group under R9-28-402(B) and who resides in one of the following settings:
   a. A noncertified medical facility, or
   b. A medical facility that is registered with AHCCCS but does not have a contract with an ALTCS program contractor, or
   c. A location outside of Arizona if the person is temporarily absent from Arizona.
2. The net income limit is 100 percent of the FBR for a person who does not meet the requirements of the 217 or 236 coverage groups specified in R9-28-402(B) and who resides in one of the following settings:
   a. At home or in an alternative HCBS setting if a person refuses HCBS service; or
   b. A room in an assisted living center, or a licensed assisted living home or center which is not registered with AHCCCS.

C. Inmate of a public institution. An inmate of a public institution is not eligible for the ALTCS program if federal financial participation (FFP) is not available.

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 369, effective January 6, 1999 (Supp. 99-1). Amended by exempt rulemaking at 7 A.A.R. 4691, effective October 1, 2001 (Supp. 01-3).

R9-28-407. Resource Criteria for Eligibility

A. The following Medicaid-eligible persons shall be deemed to meet the resource requirements for ALTCS eligibility unless ineligible due to federal and state laws regarding trusts.
1. A person receiving Supplemental Security Income (SSI);
2. A person receiving Title IV-E Foster Care Maintenance payment; or
3. A person receiving a Title IV-E Adoption Assistance.

B. Except as provided in subsection (D), if a person's ALTCS eligibility is most closely related to SSI and is not included in subsection (A), the Administration shall determine eligibility using resource criteria in 42 U.S.C. 1382(a)(3), 42 U.S.C. 1382b, and 20 CFR 416 Subpart L.

C. If a person's ALTCS eligibility is determined as a member of a family group including a dependent child, the Administration shall use the resource criteria in Section 2 of the AFDC State Plan as it existed on July 16, 1996 to determine eligibility.

D. The Administration permits exceptions to the resource criteria for a person identified in subsection (B):
1. Resources of a responsible relative (spouse or parent) are disregarded beginning the first day in the month the person is institutionalized.
2. The value of household goods and personal effects is excluded.
3. The value of oil, timber, and mineral rights is excluded.
4. The value of all of the following shall be disregarded:
   a. Term insurance;
   b. Burial insurance;
   c. Assets that a person has irrevocably assigned to fund the expense of a burial;
   d. The cash value of all life insurance if the face value does not exceed $1,500 total per insured person and the policy has not been assigned to fund a pre-need burial plan or declaratively designated as a burial fund;
   e. The value of any burial space held for the purpose of providing a place for the burial of the person, a spouse, or any other member of the immediate family;
   f. At the time of eligibility determination, $1,500 of the equity value of an asset declaratively designated as a burial fund or a revocable burial arrangement if there is no irrevocable burial arrangement; and
   g. If the person remains continuously eligible, all appreciation in the value of the assets in subsection (D)(4)(f) will be disregarded;
   h. The value of a payment refunded by a nursing facility after ALTCS approval for six months beginning with the month of receipt. The Administration shall evaluate the refund in accordance with R9-28-409 if transferred without receiving something of equal value.

E. For an institutionalized spouse, a resource disregard is allowed under 42 U.S.C. 1396r-5(h)(1), September 30, 1989, and 42 U.S.C. 1396r-5(c).

F. Trusts are evaluated in accordance with federal and state laws to determine eligibility.

G. A person is not eligible for long-term care services if countable resources exceed the following limits:
1. For a SSI-related person identified in subsection (B), the limit is $2,000 or $3,000 per couple under 20 CFR 416.1205.
2. For a person described in subsection (C), the limit is $2,000; and
3. For a person eligible under 42 U.S.C. 1396a(a)(10)(A)(i)(IV), 42 U.S.C. 1396a(a)(10)(A)(i)(VI), and 42 U.S.C. 1396a(a)(10)(A)(i)(VII), there is no resource limit.

H. A person shall provide information and verification necessary to determine the countable value of resources.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective June 6, 1989 (Supp. 89-2). Section repealed, new Section adopted by final rulemaking at 5 A.A.R. 369, effective January 6, 1999 (Supp. 99-1). Amended by exempt rulemaking at 7 A.A.R. 4691, effective October 1, 2001 (Supp. 01-3).

R9-28-408. Income Criteria for Eligibility

A. The following Medicaid-eligible persons shall be deemed to meet the income requirements for eligibility unless ineligible due to a trust in accordance with federal and state law.
1. A person receiving Supplemental Security Income (SSI);
2. A person receiving Title IV-E Foster Care Maintenance Payments; or
3. A person receiving a Title IV-E Adoption Assistance.

B. If a person's ALTCS eligibility is most closely related to SSI and the person is not included in subsection (A), the Administration shall count the income described in 42 U.S.C. 1382a and 20 CFR 416 Subpart K to determine eligibility with the following exceptions:
1. Income types excluded by 42 U.S.C. 1382a(b) for determining net income are also excluded in determining gross income to determine eligibility;
2. Income of a responsible relative (parent or spouse) is counted as part of income under 42 CFR 435.602, except that the income of a responsible relative is disregarded the month the person is institutionalized;
3. In-kind support and maintenance, under 42 U.S.C. 1382a(a)(2)(A), are excluded for both net and gross income tests;
4. The income exceptions under A.A.C. R9-22-1503(A)(2) apply to the net income test; and
5. Income described in subsection (E).

C. If a person's ALTCS eligibility is determined as a member of a family with a dependent child, the Administration shall use the methodology in Section 2 of the AFDC State Plan as it existed on July 16, 1996 to determine eligibility.

D. For a person whose eligibility is determined under 42 U.S.C. 1396a(a)(10)(A)(i)(IV), 42 U.S.C. 1396a(a)(10)(A)(i)(VI), or 42 U.S.C. 1396a(a)(10)(A)(i)(VII), the methodology in A.A.C. R9-22-1403 is used to determine eligibility in accordance with 42 CFR 435.602.

E. The following are income exceptions.
1. Disbursements from a trust are considered in accordance with federal and state law;
2. For a person defined in 42 U.S.C. 1396r-5(h)(1) income is calculated for the institutionalized spouse in accordance with 42 U.S.C. 1396r-5(b).

F. As a condition of eligibility for ALTCS, countable income shall be less than or equal to the following limits:
1. For a person in either the 217 or 236 coverage group specified in R9-28-402(B), 300 percent of the FBR;
2. For a person or a couple in the SSI-related 210 coverage group specified in R9-28-402(B), 100 percent of the FBR;
3. For a person who is under 42 U.S.C. 1396a(a)(10)(A)(i)(IV), 42 U.S.C. 1396a(a)(10)(A)(i)(VI), and 42 U.S.C. 1396a(a)(10)(A)(i)(VII) and is:
   a. A child who is at least age 6 but less than age 19; 100 percent of the FPL, adjusted by household size;

b. A child age 1 through 5, 133 percent of the FPL, adjusted by household size; or
c. A child less than age 1 or a pregnant woman, 140 percent of the FPL, adjusted by household size; or

4. For a person who is a member of a family with a dependent child, the standards specified in Section 2 of the AFDC State Plan as it existed on July 16, 1996 shall apply.

G. The Director shall determine the amount a person shall pay for the cost of ALTCS services and the post-eligibility treatment of income (share-of-cost) under A.R.S. § 36-2932(L) and 42 CFR 435.725 or 42 CFR 435.726. The Director shall consider the following in determining the share-of-cost:

1. Income types excluded by 42 U.S.C. 1382a(b) for determining net income are excluded in determining share-of-cost;
2. SSI benefits paid under 42 U.S.C. 1382(e)(1)(E) and (G) to a person who receives care in a hospital or nursing facility are not included in calculating the share-of-cost;
3. The share-of-cost of a person with a spouse is calculated as follows:
   a. If an institutionalized person has a community spouse under 42 U.S.C. 1396r-5(h), share-of-cost is calculated under R9-28-410 and 42 U.S.C. 1396r-5(b) and (d);
   b. If an institutionalized person has a spouse who does not live at home but is absent due to marital estrangement, or who resides in a medical institution or in an approved setting specified in R9-28-504, only the institutionalized person's income is used for the share-of-cost. The spousal deduction under subsection (F)(5)(b) is not allowed; and
   c. For all other persons, the share-of-cost is calculated by dividing the combined income of the spouses in half;
4. Income assigned to a trust is considered in accordance with federal and state law.
5. The following expenses are deducted from the share-of-cost of an eligible person to calculate their share-of-cost:
   a. A personal-needs allowance equal to 15 percent of the FBR for a person residing in a medical institution for a full calendar month. A personal-needs allowance equal to 300 percent of the FBR for a person who receives or intends to receive HCBS or who resides in a medical institution for less than the full calendar month;
   b. A spousal allowance, equal to the FBR minus the income of the spouse, if a spouse but no children remain at home;
   c. A family allowance equal to the standard specified in Section 2 of the AFDC State Plan as it existed on July 16, 1996 for the number of family members minus the income of the family members if a spouse and children remain at home;
   d. Expenses for the medical and remedial care services listed in subsection (6) if these expenses have not been paid or are not subject to payment by a third-party, but the person still has the obligation to pay the expense, and one of the following conditions is met:
      i. The expense represents a current payment (that is, a payment made and reported to the Administration during the application period or a payment reported to the Administration no later than the end of the month following the month in which the payment occurred) and the expense has not previously been allowed a share-of-cost deduction; or
      ii. The expense represents the unpaid balance of an allowed, noncovered medical or remedial expense, and the expense has not been previously deducted from the share-of-cost;
   e. An amount determined by the Director for the maintenance of a single person's home for not longer than six months if a physician certifies that the person is likely to return home within that period; or
   f. An amount for Medicare and other health insurance premiums, deductibles, or coinsurance not subject to third-party reimbursement; and
6. In the post-eligibility calculation of income, the Administration recognizes the following medical and remedial care services are not covered under the Title XIX State Plan, nor covered by a program contractor to a person determined to need institutional services under this Article when the medical or remedial care services are medically necessary for a person:
   a. Nonemergency dental services for a person who is age 21 or older;
   b. Hearing aids and hearing aid batteries for a person who is age 21 or older;
   c. Nonemergency eye care and prescriptive lenses for a person who is age 21 or older;
   d. Chiropractic services, including treatment for subluxation of the spine, demonstrated by x-ray;
   e. Orthognathic surgery for a person 21 years of age or older; and
   f. On a case-by-case basis, other noncovered medically necessary services that a person petitions the Administration for and the Director approves.

H. A person shall provide information and verification of income under A.R.S. § 36-2934(G) and 20 CFR 416.203.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 369, effective January 6, 1999 (Supp. 99-1). Amended by exempt rulemaking at 7 A.A.R. 4691, effective October 1, 2001 (Supp. 01-3).

R9-28-409. Transfer of Assets

A. The provisions in this Section apply to an institutionalized person who has, or whose spouse has, transferred assets and received less than the fair market value (uncompensated value) specified in A.R.S. § 36-2934(B) and 42 U.S.C. 1396p(c)(1)(A), August 10, 1993, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.

B. A person shall report transfer of assets. The Administration shall evaluate all transfers occurring during or after the look-back period under 42 U.S.C. 1396p(c)(1)(B), August 10, 1993, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments. The person shall provide verification of any transfer.

C. Certain transfers are permitted under 42 U.S.C. 1396p(c)(2), August 10, 1993, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.

D. If the Administration determines a disqualification period applies due to a transfer, and the person is otherwise eligible, the person may remain eligible for ALTCS acute care services but shall be disqualified for receiving ALTCS coverage under 42 U.S.C. 1396p(c)(1)(C), August 10, 1993, which is incorpo-

rated by reference and on file with the Administration and the Secretary of State. This incorporation contains no future editions or amendments.

E. The period of disqualification for transfers shall be computed by dividing the cumulative uncompensated value of the transferred assets by the average cost for a private pay patient for nursing care services at the time of application.
1. For single or multiple transfers occurring in the same calendar month, the sum of all uncompensated value shall be divided by the monthly private pay rate. Disregarding fractions, the result of this calculation equals the number of months of ineligibility.
2. For multiple transfers occurring in different calendar months, the total uncompensated value for each transfer of assets shall be determined under subsection (E)(1) but, if the periods of ineligibility overlap, the period of ineligibility shall run consecutively. Fractions are disregarded at the end of the entire period.
3. For multiple transfers occurring in different months, the total uncompensated value for each transfer shall be determined under subsection (E)(1), but if the periods of ineligibility do not overlap, each period of ineligibility shall be treated under subsection (E)(1).

F. Transfers of assets for less than fair market value are presumed to have been made to establish eligibility for ALTCS services.

G. Rebuttal of disqualification.
1. A person found ineligible for ALTCS services by reason of a transfer of assets for uncompensated value shall have the right to rebut the disqualification under 42 U.S.C. 1936p(c)(2)(C), August 10, 1993, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.
2. The person shall have the burden of rebutting the presumption.
3. If a person rebuts a transfer on the basis of debt repayment, the Administration shall determine the validity of the debt under A.R.S. § 44-101.

H. Undue hardship. A period of disqualification for ALTCS services due to a transfer may be waived by the Director if the person is otherwise eligible and a substantial showing is made by clear and convincing evidence that:
1. The person is unable to obtain necessary medical care without ALTCS eligibility, and
2. Is in imminent danger of death.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 369, effective January 6, 1999 (Supp. 99-1).

R9-28-410. Community Spouse

A. The methodology in this Section applies to an institutionalized person who is legally married and has a spouse who resides in the community.

B. If the institutionalized person's most current period of continuous institutionalization began on or after September 30, 1989, the Administration shall use the methodology for the treatment of resources under 42 U.S.C. 1396r-5(c), September 30, 1989, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.
1. The following resource criteria shall be used in addition to the criteria specified in R9-28-407:
   a. Resources owned by a couple at the beginning of the first continuous period of institutionalization from and after September 30, 1989, shall be computed from the first day of institutionalization. The total value of resources owned by the institutionalized spouse and the community spouse, and a spousal share equal to 1/2 of the total value, are computed under 42 U.S.C. 1396r-5(c)(1), September 30, 1989, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation contains no future editions or amendments.
   b. The Community Spouse Resource Reduction (CSRD) is calculated under 42 U.S.C. 1396r-5(f)(2), September 30, 1989, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.
   c. The CSRD is subtracted from the total resources of the couple to determine the amount of the couple's resources considered available to the institutionalized spouse at the time of application under 42 U.S.C. 1396r-5(c)(2), September 30, 1989, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.
      i. Resources in excess of the CSRD must be equal to or less than the standard for a person specified in R9-28-407.
      ii. The CSRD is allowed as a deduction for 12 consecutive months beginning with the first month in which the institutionalized spouse is eligible for ALTCS benefits. Beginning with the 13th month, the separate property of the institutionalized spouse must be within the resource standard for a person specified in R9-28-407.
      iii. If a person, previously eligible for ALTCS using the community spouse policy, reapplies for ALTCS after a break in institutionalization of more than 30 days, the CSRD will be allowed as a deduction from resources for another 12-month period.
2. Resources are excluded as specified in R9-28-407, except that one vehicle is totally excluded regardless of its value, and any additional vehicles are included using equity value.
3. The Director may grant eligibility if the Administration determines a denial of eligibility would create an undue hardship.

C. The community spouse policy applies to the income eligibility and post-eligibility treatment of income beginning September 30, 1989, regardless of when the first period of institutionalization began.
1. Income payments are attributed to the institutionalized spouse and the community spouse under 42 U.S.C. 1396r-5(b)(2), October 1, 1993, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments.
2. Income is excluded specified in R9-28-408.
3. The institutionalized spouse's income eligibility is determined under community property rules in which the income of the spouse is combined and divided by 2. Income eligibility shall be based on the income received in the person's name if the person is not eligible using community property rules.
4. The items described in 42 U.S.C. 1396r-5(d)(1) and (2) are allowed as deductions from the institutionalized

spouse's income in determining share-of-cost and 42 U.S.C. 1396r-5(d)(1) and (2), September 30, 1989, are incorporated by reference and on file with the Administration and the Secretary of State and contain no future editions or amendments:
   a. A personal-needs allowance specified in R9-28-408(f)(5)(a);
   b. A community spouse monthly income allowance, but only to the extent that the institutionalized spouse's income is made available to or for the benefit of the community spouse;
   c. A family allowance for each family member equal to 1/3 of the amount remaining after deducting the countable income of the family member from a minimum monthly-needs allowance;
   d. An amount for medical or remedial services specified in R9-28-408; and.
   e. An amount for Medicare and other health insurance premiums, deductibles, or coinsurance not subject to third-party reimbursement.

D. Transfers.
1. The institutionalized spouse may transfer to any of the following an amount of resources equal to the CSRD without affecting eligibility under 42 U.S.C. 1396r-5(f), September 30, 1989, incorporated by reference and on file with the Administration and the Secretary of State. This incorporation by reference contains no future editions or amendments. The institutionalized spouse may transfer resources to:
   a. The community spouse; or
   b. Someone other than the community spouse if the resources are for the sole benefit of the community spouse.
2. The institutionalized spouse is allowed a period of 12 consecutive months, beginning with the first month of eligibility, to transfer resources in excess of the resource standard in R9-28-407(E)(2) to the persons listed in subsection (D)(1).
3. All other transfers by the institutionalized person or transfers by the community spouse are treated under the provisions in R9-28-409.

E. Specific hearing rights apply to a person whose eligibility is determined under this Section.
1. The institutionalized spouse or the community spouse is entitled to a fair hearing if dissatisfied with the determination of any of the following:
   a. The community spouse monthly income allowance;
   b. The amount of monthly income allocated to the community spouse;
   c. The computation of the spousal share of resources;
   d. The attribution of resources; or
   e. The CSRD.
2. The hearing officer may increase the amount of the MMMNA if either spouse establishes that the community spouse needs income above the established MMMNA due to exceptional circumstances.
3. The hearing officer may increase the amount of the CSRD to allow the community spouse to retain enough resources to generate income to meet the MMMNA. The community spouse may be allowed to retain an amount of resources necessary to purchase a single premium life annuity that would furnish monthly income sufficient to bring the community spouse's total monthly income up to the MMMNA.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 369, effective January 6, 1999 (Supp. 99-1).

R9-28-411. Changes, Redeterminations, and Notices

A. Reporting and verifying changes.
1. A person shall report to the ALTCS eligibility office the following changes for a person, a person's spouse, or a person's dependent children under 42 CFR 435.916:
   a. A change of address;
   b. An admission to or discharge from a medical facility, public institution, or private institution;
   c. A change in the household's composition;
   d. A change in income;
   e. A change in resources;
   f. A determination of eligibility for other benefits;
   g. A death;
   h. A change in marital status;
   i. An improvement in the person's medical condition;
   j. A change in school attendance;
   k. A change in Arizona state residency;
   l. A change in citizenship or alien status;
   m. Receipt of an SSN under R9-28-405;
   n. A transfer of assets under R9-28-409;
   o. A change in trust income and disbursements in accordance with state and federal law;
   p. A change in first- or third-party liability that may be responsible for payment of all or a portion of the person's medical costs;
   q. A change in first-party medical insurance premiums;
   r. A change in the household expenses used to calculate the community spouse monthly income allowance described in R9-28-410;
   s. A change in the amount of the community spouse monthly income allowance that is provided to the community spouse by the institutionalized spouse under R9-28-410; and
   t. Any other change that may affect the person's eligibility or share-of-cost.
2. A change shall be reported either orally or in writing and shall include:
   a. The name of the affected person;
   b. The change;
   c. The date the change happened;
   d. The name of the person reporting the change; and
   e. The person's Social Security or case number, if known, under A.R.S. § 36-2934.
3. A person shall provide verification of changes upon request, under A.R.S. § 36-2934, if needed to redetermine eligibility or to re-calculate post-eligibility computation of income.
4. A person shall report anticipated changes in advance, as soon as the future event becomes known.
5. A person shall report other changes events within 10 days of the date the change occurred.

B. Processing of changes and redeterminations. A person's eligibility shall be redetermined at least one time every 12 months and when changes occur, under 42 CFR 435.916. A person's share-of-cost, specified in R9-28-408, shall be redetermined whenever a change occurs that may affect the post-eligibility computation of income.

C. Actions that may result from a redetermination or change. Processing a redetermination or change shall result in one of the following findings:
1. No change in eligibility or the post-eligibility computation of income;

2. Discontinuance of eligibility if a condition of eligibility is no longer met;
3. Suspension of eligibility if a condition of eligibility is temporarily not met;
4. A change in the post-eligibility computation of income and the person's share-of-cost; or
5. A change in service from ALTCS to ALTCS acute care services, or from ALTCS acute care services to ALTCS, caused by changes in a person's living arrangement, specified in R9-28-406, or a transfer of assets specified in R9-28-409.

D. Notices.
1. Contents of notice. The Administration shall issue a notice when an action is taken regarding a person's eligibility or computation of share-of-cost. The notice shall contain the following information:
   a. A statement of the action being taken;
   b. The effective date of the action;
   c. The specific reason for the intended action;
   d. The actual figures used in the eligibility determination and specify the amount by which the person exceeds income standards if eligibility is being discontinued because either a person's resources exceed the resource limit specified in R9-28-407(E), or a person's income exceeds the income limit specified in R9-28-408(E);
   e. The specific law or regulation that supports the action, or a change in federal or state law that requires an action;
   f. An explanation of a person's right to request an evidentiary hearing; and
   g. An explanation of the date by which a request for hearing must be received so that eligibility or the current share-of-cost may be continued.
2. Advance notice of changes in eligibility or share-of-cost. "Advance notice" means a notice that is issued to a person at least 10 days before the effective date of change, under 42 CFR 435.919. Except as specified in subsection (D)(3), advance notice shall be issued whenever the following adverse action is taken:
   a. To discontinue or suspend eligibility if an eligible person no longer meets a condition of eligibility, either ongoing or temporarily;
   b. To affect post-eligibility computation of income and increase a person's share-of-cost; or
   c. To reduce benefits from ALTCS to ALTCS acute care services due to a change from a long-term care living arrangement to an acute care living arrangement, specified in R9-28-406(B), or due to a transfer with uncompensated value, specified in R9-28-409.
3. Under 42 CFR 431.213, notice shall be issued to a person to discontinue eligibility or to increase the share-of-cost, no later than the effective date of action if:
   a. A person provides a clear, written statement, signed by the person, that a person no longer desires services;
   b. A person provides information that requires termination of eligibility or an increase in the share-of-cost and the person signs a clear written statement waiving advance notice;
   c. A person cannot be located and mail sent to that person has been returned as undeliverable;
   d. A person has been admitted to a public institution where the person is ineligible for ALTCS under R9-28-406; or
   e. A person has been approved for Medicaid in another state;
   f. The Administration has information that confirms the death of the person;
   g. The person's primary care provider has prescribed a change in the level of medical care; or
   h. The notice involves an adverse determination regarding the PAS, specified in A.R.S. § 36-2536.

E. Transitional. HCBS services may be provided to a person who is no longer at risk of institutionalization but who continues to require significant long-term care services under A.R.S. § 36-2936(D).

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 369, effective January 6, 1999 (Supp. 99-1).

R9-28-412. General Enrollment

A. Program contractors. The Administration shall enroll each ALTCS member with one of the following ALTCS program contractors or the FFS program as specified in A.R.S. § 36-2933:
1. An elderly and physically disabled (EPD) program contractor,
2. The developmentally disabled (DD) program contractor,
3. A tribal program contractor, or
4. The AHCCCS fee-for-service program.

B. Annual enrollment. If an ALTCS member is elderly or physically disabled and lives in a GSA served by more than one program contractor, a member may change program contractors during the annual enrollment choice period or as permitted as specified in R9-28-507.

Historical Note
New Section adopted by final rulemaking at 5 A.A.R. 369, effective January 6, 1999 (Supp. 99-1). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1).

R9-28-413. Enrollment with an EPD Program Contractor

A. A member's enrollment with one EPD program contractor. The Administration shall enroll an ALTCS elderly or physically disabled member with the one EPD program contractor assigned to that GSA.

B. New member makes a choice of an EPD program contractor on or after October 1, 2000. The Administration shall provide a new member an opportunity to choose an EPD program contractor, if an ALTCS member is elderly or physically disabled, and lives in a GSA served by more than one EPD program contractor.

C. New member who makes no choice of an EPD program contractor on or after October 1, 2000. The Administration shall enroll an elderly or physically disabled new member that lives in a GSA with more than one EPD program contractor and who makes no choice of an EPD program contractor under the following:
1. Criteria. The Administration will prioritize enrollment based on continuity of care and enroll a member with an EPD program contractor chosen under the following criteria, including but not limited to:
   a. A member's living arrangement, and
   b. A member's primary care practitioner.
2. Algorithm. The Administration shall enroll a member through an algorithm as specified in contract, when a member has a choice of more than one EPD program contractor and the criteria in subsection (C)(1) does not apply.

D. A member enrolled with an EPD program contractor prior to October 1, 2000, and is enrolled in the system after October 1, 2000.
1. Choice. The Administration shall request an existing member residing in a GSA with more than one EPD program contractor to choose an EPD program contractor.
2. A member makes no choice. If a member makes no choice, the Administration will continue enrollment with a member's existing EPD program contractor. If that existing EPD program contractor is not awarded a bid, the member will be enrolled with an EPD program contractor as specified in Section (C).

Historical Note
New Section adopted by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1).

R9-28-414. Enrollment with the DD Program Contractor
A. A member's DD program contractor. The Administration shall enroll a member with the DES Division of Developmental Disabilities as specified in A.R.S. § 36-2940, if the ALTCS member is eligible for services for the developmentally disabled services.
B. Indian on and off reservation. The Administration shall enroll an Indian ALTCS member who is developmentally disabled, with the DES Division of Developmental Disabilities. This enrollment shall be made whether the member is considered to be residing on or off reservation.

Historical Note
New Section adopted by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1).

R9-28-415. Enrollment with a Tribal Program Contractor
A. On-reservation. The Administration shall enroll an Indian ALTCS member who is elderly or physically disabled with the ALTCS tribal program contractor as specified in A.R.S. § 36-2932 if a person:
1. Lives on-reservation of a tribe participating as an ALTCS tribal program contractor, or
2. Lived on-reservation of a tribe participating as an ALTCS tribal program contractor immediately prior to placement in an off-reservation NF or alternative HCBS setting.

B. Off-reservation. The Administration shall enroll an Indian ALTCS member who is elderly or physically disabled with an EPD program contractor under R9-28-413, if a member lives off-reservation, and has no on-reservation status as specified in subsection (A)(2).

Historical Note
New Section adopted by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1).

R9-28-416. Enrollment with the FFS Program
A. No tribal or EPD program contractor in GSA. The Administration shall enroll an ALTCS elderly or physically disabled member who resides in an area with no ALTCS tribal program contractor or EPD program contractor in the AHCCCS FFS program under A.R.S. § 36-2945.
B. Prior period coverage. The Administration shall enroll a member in AHCCCS fee-for-service program if a member is eligible for ALTCS services only during prior period coverage.

Historical Note
New Section adopted by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1). Amended by exempt rulemaking at 7 A.A.R. 4691, effective October 1, 2001 (Supp. 01-3).

R9-28-417. Notification Requirements
A. Administration responsibilities. The Administration shall notify a member's program contractor when a member is enrolled or disenrolled from the ALTCS program. The Administration shall include the following in the notification:
1. The member's name,
2. The member's identification number,
3. The member's effective date of enrollment or disenrollment, and
4. The member's share-of-cost on a monthly enrollment roster.

B. Program contractor's responsibilities. The program contractor shall notify the Administration if an ALTCS member has any change that may affect eligibility including but not limited to:
1. A change in residential address,
2. A change in medical or functional condition,
3. A change in living arrangement including:
   a. Alternative HCBS setting,
   b. Home,
   c. Nursing facility, or
   d. Other living arrangement not specified in this subsection,
4. Change in resource or income, or
5. Death.

Historical Note
New Section adopted by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1).

R9-28 418. Disenrollment
The Administration shall disenroll an ALTCS member the last day of the month following receipt of appropriate notification under R9-28-411 except under the following situations:
1. The Administration shall disenroll an ALTCS member who dies. A member's last day of enrollment shall be the date of death.
2. The Administration may disenroll a member immediately if requested.
3. The Administration shall disenroll a member effective the date of the hearing decision if ALTCS benefits have been continued pending an eligibility appeal decision and the discontinuance is upheld, as specified in 9 A.A.C. 28, Article 8.

Historical Note
New Section adopted by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1).

ARTICLE 5. PROGRAM CONTRACTOR AND PROVIDER STANDARDS

R9-28-501. Repealed

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1).

R9-28-502. Long-term Care Provider Requirements
A. A provider shall obtain any necessary authorization from the program contractor or the Administration for services provided to an ALTCS-eligible person or member.
B. A provider shall maintain and make available to a program contractor and to the Administration, financial, and medical records for not less than five years from the date of final payment, or for records relating to costs and expenses to which the Administration has taken exception, five years after the date of final disposition or resolution of the exception. The records

shall meet the uniform accounting standards as specified by the Administration, and accepted practices for maintenance of medical records, including detailed specification of all patient services delivered, the rationale for delivery, and the service date.

C. A provider shall not submit a claim, demand, or otherwise collect payment from an eligible person or member for ALTCS-covered services paid to the provider by the Administration or program contractor. A provider shall not bill or attempt to collect payment, directly or through a collection agency, from a person claiming to be ALTCS eligible without first receiving verification from the Administration that the person was ineligible for ALTCS on the date of service, or that services provided were not ALTCS-covered services.

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended subsection (E) effective June 6, 1989 (Supp. 89-2). Amended effective December 8, 1997 (Supp. 97-4).

R9-28-503. Licensure and Certification for Long-term Care Institutional Facilities

A. Nursing facilities that provide services to an eligible person or member shall be Medicare and Medicaid certified and meet the requirements in 42 CFR 442, September 28, 1995, and 42 CFR 483, September 29, 1995, incorporated by reference and on file with the Administration and the Office of the Secretary of State, and meet the Arizona Department of Health Services' rules for licensure. This incorporation by reference contains no future editions or amendments.

B. An ICF-MR shall be Medicaid certified and meet the requirements in A.R.S. § 36-2939(B)(1) and 42 CFR 442, Subpart C, November 20, 1992, and 42 CFR 483, September 29, 1995, incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.

C. All nursing facilities and ICF-MRs that provide services to an eligible person or member shall be registered as providers with the Administration. To be registered, a provider shall meet the licensure and certification requirements of subsections (A) or (B) and have a current provider agreement with a program contractor.

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective June 6, 1989 (Supp. 89-2). Amended effective November 5, 1993 (Supp. 93-4). Amended effective December 8, 1997 (Supp. 97-4).

R9-28-504. Standards of Participation, Licensure, and Certification for HCBS Providers

A. All noninstitutional long-term care providers shall be registered with the Administration and meet the requirements of the Arizona Department of Health Services' rules for licensure, if applicable.

B. Additional qualifications:
1. A community residential setting and a group home for an individual with developmental disabilities shall be licensed by the appropriate regulatory agency of the state according to 6 A.A.C. 6;
2. An adult foster care home shall be certified or licensed according to 9 A.A.C. 10;
3. A home health service agency shall be Medicare-certified and licensed according to 9 A.A.C. 10;
4. An individual providing a homemaker service shall meet the requirements specified in contract;
5. An individual providing a personal care service shall meet the requirements specified in contract;
6. An adult day health provider shall be licensed according to 9 A.A.C. 10;
7. A therapy provider shall meet the following requirements:
   a. A physical therapy provider shall meet the requirements in 4 A.A.C. 24;
   b. A speech therapy provider shall be certified by the American Speech, Language, and Hearing Association;
   c. An occupational therapy provider shall meet the requirements in 4 A.A.C. 43; and
   d. A respiratory therapy provider shall meet the requirements in 4 A.A.C. 45;
8. A respite provider shall meet the requirements specified in contract;
9. A hospice provider shall be Medicare-certified and licensed according to 9 A.A.C. 10;
10. A provider of home delivered meal service shall comply with hygiene requirements in 9 A.A.C. 8;
11. A provider of non-emergency transportation shall be licensed by the Arizona Department of Transportation, Motor Vehicle Division;
12. A provider of emergency transportation shall meet the licensure requirements in 9 A.A.C. 13;
13. A day care provider for the developmentally disabled shall meet the licensure requirements in 6 A.A.C. 6;
14. A habilitation provider shall meet the requirements in A.A.C. R6-6-1523 or the therapy requirements in this Section;
15. Another service provider approved by the director shall meet the requirements specified in a program contractor's contract with the Administration;
16. A behavioral health provider shall have all applicable state licenses or certifications, and meet the service specifications in A.A.C. R9-22-1205;
17. An assisted living home or a residential unit as defined in A.R.S. § 36-401 and as authorized in A.R.S. § 36-2939.

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective June 6, 1989 (Supp. 89-2). Amended effective July 13, 1992 (Supp. 92-3). Amended effective November 5, 1993 (Supp. 93-4). Amended effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 5 A.A.R. 874, effective March 4, 1999 (Supp. 99-1).

R9-28-505. Standards, Licensure, and Certification for Providers of Hospital and Medical Services

A. A provider of hospital and medical care services shall be registered with the Administration.

B. With the exception of an Indian Health Service (IHS) hospital and a Veterans Administration hospital, which must be Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accredited, a provider of hospital services shall be licensed by the Arizona Department of Health Services, be JCAHO accredited, and meet the requirements in 42 CFR 482, September 9, 1996, and 42 CFR 456(C), September 29, 1978, incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation contains no future editions or amendments.

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective December 8, 1997 (Supp. 97-4).

R9-28-506. Reserved

R9-28-507. Program Contractor General Requirements

A. To participate in the ALTCS program, through a program contractor or directly through the Administration, a provider of ALTCS-covered services shall be registered with the Administration.

B. ALTCS program contractors shall ensure that providers of service meet the requirements of this Article.

C. Each ALTCS program contractor shall maintain member service records. These shall include, at a minimum, a case management plan, medical records, encounter data, grievances, complaints, and service information for each ALTCS member. A program contractor shall ensure that all member service records are retained for five years from the date of final payment. For records relating to costs and expenses to which the Administration has taken exception, member service records are retained for five years after the date of final disposition or resolution of the exception. A program contractor shall provide ALTCS member service records or copies of member service records to the Administration upon request.

D. An ALTCS program contractor shall produce and distribute information materials to each enrolled ALTCS member or designated representative within 12 days after receipt of notification of enrollment from the Administration. The information, which shall be approved by the Administration before distribution, shall include:
1. A description of all covered services as specified in contract;
2. An explanation of service limitations and exclusions;
3. An explanation of the procedure for obtaining services, including a notice stating that the program contractor is liable only for those services authorized by an ALTCS member's case manager;
4. An explanation of the procedure for obtaining emergency services;
5. An explanation of the procedure for filing a grievance and appeal; and
6. An explanation of when plan changes may occur as specified in contract.

E. An ALTCS program contractor shall submit encounter reports on services rendered to each member within 120 days after the month of service, except for services with Medicare coverage, which shall be submitted within 180 days after the month of service.

F. An ALTCS program contractor or subcontractor shall collect the member's share of cost and report the amount collected as specified in their contract to the program contractor or Administration, if necessary.

G. An ALTCS program contractor shall monitor a trust fund account for an institutionalized ALTCS member to verify that expenditures from the member's trust fund account are in compliance with federal regulations.

H. A program contractor shall ensure that an institutionalized ALTCS member transferred to an acute facility for services is, whenever possible, returned to the original institution upon completion of acute care.

I. A program contractor shall ensure that an institutionalized ALTCS member granted therapeutic leave is returned to the same bed in the original institution upon completion of the therapeutic leave.

J. A program contractor shall ensure that services are paid under A.A.C. R9-22-705.

K. An EPD program contractor shall meet the marketing provisions in A.A.C. R9-22-505.

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective June 6, 1989 (Supp. 89-2). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1).

R9-28-508. Repealed

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective April 25, 1990 (Supp. 90-2). Amended effective December 8, 1997 (Supp. 97-4). Section repealed by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1).

R9-28-509. Reserved

R9-28-510. Case Management

A. Each eligible person and member shall be assigned a case manager to:
1. Identify,
2. Plan,
3. Coordinate,
4. Monitor, and
5. Reassess the need for and provision of long-term care services.

B. The case manager shall:
1. Ensure that appropriate ALTCS placement and services are provided for an eligible person or member within 30 days of notification of enrollment;
2. Complete a case management plan when an eligible person or member is enrolled in ALTCS. The case manager shall re-evaluate and revise the plan when the eligible person or member:
   a. Transfers to another facility,
   b. Transfers to a hospital,
   c. Has a change in the in-home service package, or
   d. Has a change in the level of care.
3. Specify the services to be received by an eligible person or member, including the:
   a. Duration,
   b. Scope of services,
   c. Units of service,
   d. Frequency of service delivery,
   e. Provider of services, and
   f. Effective time period.
4. Authorize services for an eligible person or member who continues to be financially and medically eligible for services;
5. Coordinate with a primary care provider in determining the necessary services for an eligible person or member, including hospital and medical services;
6. Ensure that an eligible person or member participates in the preparation of the eligible person's or member's case management plan;
7. Assist an eligible person or member to maintain or progress toward the highest level of functioning;
8. Monitor receipt of services by an eligible person or member;
9. Initiate a transfer to AHCCCS or other programs, where appropriate, when ALTCS HCBS services are no longer necessary;
10. Submit written justification to the case manager's supervisor to include HCBS in the case management plan, if the services exceed 80% of the institutional cost;

11. Ensure that records are transferred when an eligible person or member is transferred from a facility or provider to a new facility or provider;
12. Perform additional monitoring of an eligible person or member with rehabilitation potential, whose condition is fragile or unstable, whose case management plan is marginally cost effective, or whose use of medical and hospital services is unusual;
13. Revise a case management plan for an eligible person or member according to the terms of the contract; and
14. Arrange behavioral health services if necessary and, if the case manager does not meet the definition of a behavioral health professional according to A.A.C. R9-22-1201, have initial and quarterly consultation and collaboration with a behavioral health professional to review the treatment plan.

C. A program contractor shall submit the initial case management plan and all revisions to the Administration within 14 days of initially preparing or revising the plan.

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective June 6, 1989 (Supp. 89-2). Amended effective July 13, 1992 (Supp. 92-3). Amended effective November 5, 1993 (Supp. 93-4). Amended effective December 8, 1997 (Supp. 97-4).

R9-28-511. Quality Management/Utilization Management (QM/UM) Requirements
A program contractor shall:

1. Comply with all requirements specified in A.A.C. R9-22-522; and
2. Submit a quarterly utilization control report within time lines specified in contract and specified in 42 CFR 456 Subparts C, D, and F, December 1, 1986, incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective June 6, 1989 (Supp. 89-2). Amended under an exemption from the provisions of the Administrative Procedure Act effective March 1, 1993 (Supp. 93-1). Amended effective November 5, 1993 (Supp. 93-4). Amended effective December 8, 1997 (Supp. 97-4). Amended by final rulemaking at 5 A.A.R. 874, effective March 4, 1999 (Supp. 99-1).

R9-28-512. Expired

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective December 8, 1997 (Supp. 97-4). Section expired under A.R.S. § 41-1056(E) at 8 A.A.R. 4851, effective October 9, 2002 (Supp. 02-4).

R9-28-513. Program Compliance Audits
The Administration and its contractors shall meet the requirements specified in A.A.C. R9-22-521 for an ALTCS eligible person or member.

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective December 8, 1997 (Supp. 97-4).

R9-28-514. Release of Safeguarded Information by the Administration and Contractors
The Administration, program contractors, providers, and noncontracting providers shall meet the requirements specified in A.A.C. R9-22-512 for an ALTCS applicant, eligible person, or member.

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective December 8, 1997 (Supp. 97-4).

R9-28-515. Discrimination prohibition and equal opportunity
The program contractor and provider shall comply with discrimination prohibitions and equal opportunity requirements as set forth in A.A.C. R9-22-513 and R9-22-514.

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3).

ARTICLE 6. RFP AND CONTRACT PROCESS

Article 6, consisting of Sections R9-28-601 through R9-28-610, repealed; new Article 6, consisting of Sections R9-28-601 through R9-28-608, adopted by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1).

R9-28-601. General Provisions

A. The Director has full operational authority to adopt rules for the RFP process and the award of contract under A.R.S. § 36-2944.

B. The Administration shall follow the provisions under 9 A.A.C. 22, Article 6 for members, subject to limitations and exclusions under that Article, unless otherwise specified in this Chapter.

C. The Administration shall award contracts under A.R.S. § 36-2932 to provide services under A.R.S. § 36-2939.

D. The Administration is exempt from the procurement code under A.R.S. § 41-2501.

E. The Administration and contractors shall retain all records relating to contract compliance for five years under A.R.S. § 36-2932 and dispose of the records under A.R.S. § 41-2550.

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective August 11, 1997 (Supp. 97-3). Amended by final rulemaking at 5 A.A.R. 874, effective March 4, 1999 (Supp. 99-1). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1). Amended by final rulemaking at 8 A.A.R. 444, effective January 10, 2002 (Supp. 02-1).

R9-28-602. RFP
The ALTCS RFP for a program contractor serving members who are EPD shall meet the requirements of A.R.S. §§ 36-2944, A.R.S. § 36-2939, A.A.C. R9-22-602, and Articles 2 and 11 of this Chapter.

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective June 6, 1989 (Supp. 89-2). Amended effective August 11, 1997 (Supp. 97-3). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1). Amended by final rulemaking at 8 A.A.R. 444, effective January 10, 2002 (Supp. 02-1).

R9-28-603. Contract Award
The Administration shall award a contract under A.R.S. § 36-2944 and A.A.C. R9-22-603.

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective August 11, 1997 (Supp. 97-3). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 444, effective January 10, 2002 (Supp. 02-1).

R9-28-604. Contract or Proposal Protests; Appeals
Contract or proposal protests or appeals shall be under A.A.C. R9-22-604 and Article 8 of this Chapter.

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective August 11, 1997 (Supp. 97-3). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 444, effective January 10, 2002 (Supp. 02-1).

R9-28-605. Waiver of Contractor's Subcontract with Hospitals
A contractor's subcontract with hospitals may be waived under A.A.C. R9-22-605.

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective August 11, 1997 (Supp. 97-3). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 444, effective January 10, 2002 (Supp. 02-1).

R9-28-606. Contract Compliance Sanction
A. The Administration shall follow sanction provisions if criteria under A.A.C. R9-22-606 are met.
B. The Administration shall apply remedies found in 42 CFR 488, Subpart F, effective May 17, 1999, incorporated by reference and on file with the Administration and the Office of the Secretary of State, for a nursing facility that does not meet requirements of participation under 42 U.S.C. 1396r. This incorporation by reference contains no future editions or amendments.

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective August 11, 1997 (Supp. 97-3). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1). Section repealed; new Section made by final rulemaking at 8 A.A.R. 444, effective January 10, 2002 (Supp. 02-1).

R9-28-607. Repealed

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective November 5, 1993 (Supp. 93-4). Amended effective August 11, 1997 (Supp. 97-3). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1). Section repealed by final rulemaking at 8 A.A.R. 444, effective January 10, 2002 (Supp. 02-1).

R9-28-608. Repealed

Historical Note
New Section adopted by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1). Section repealed by final rulemaking at 8 A.A.R. 444, effective January 10, 2002 (Supp. 02-1).

R9-28-609. Repealed

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Section repealed by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1).

R9-28-610. Repealed

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended under an exemption from the provisions of the Administrative Procedure Act effective March 1, 1993 (Supp. 93-1). Section repealed by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1).

ARTICLE 7. STANDARDS FOR PAYMENTS

R9-28-701. Scope of the Administration's Liability
The Administration shall bear no liability for providing covered services or completing a plan of treatment for a member beyond the date of termination of the member's eligibility.

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended by final rulemaking at 8 A.A.R. 444, effective January 10, 2002 (Supp. 02-1).

R9-28-702. Prohibition Against Charges to Members
A. Except as provided in subsection (B), an AHCCCS registered provider shall not do either of the following, unless services are not covered or without first receiving verification from the Administration that the person was ineligible for AHCCCS on the date of service:
1. Charge, submit a claim to, demand or collect payment from a person claiming to be AHCCCS eligible; or
2. Refer or report a person claiming to be AHCCCS eligible to a collection agency or credit reporting agency.

B. An AHCCCS registered provider may charge, submit a claim to, demand or collect payment from a member as follows:
1. To collect an authorized copayment;
2. To pay for non-covered services;
3. To recover from a member that portion of a payment made by a third-party to the member if the payment duplicates AHCCCS paid benefits and is not assigned to a contractor under A.A.C. R9-22-1002(B). An AHCCCS registered provider that makes a claim under this Article shall not charge more than the actual, reasonable cost of providing the covered service; or
4. To bill a member for medical expenses incurred during a period when the member intentionally withheld information or intentionally provided inaccurate information pertaining to the member's AHCCCS eligibility or enrollment that caused the payment to the provider to be reduced or denied.

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 3340, effective July 15, 2002 (Supp. 02-3).

R9-28-703. Claims

An AHCCCS registered provider shall submit all claims for covered services rendered to:

1. A member enrolled with a program contractor, to the program contractor under A.A.C. R9-22-705 and this Article; or
2. A FFS member, to the Administration for payment under A.A.C. R9-22-703 and this Article.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective November 5, 1993 (Supp. 93-4). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 3340, effective July 15, 2002 (Supp. 02-3).

R9-28-704. Transfer of Payments

A. Business agent. For purposes of this Section, a business agent is a firm such as a billing service or accounting firm that renders statements and receives payment in the name of the program contractor or AHCCCS registered provider.

B. Allowable transfer of payments. The Administration or a program contractor may make payments to other than an AHCCCS registered provider, and the Administration may make payments to other than a program contractor after considering whether:

1. There is an assignment to a government agency or there is an assignment under a court order; or
2. A business agent's compensation for this service is:
   a. Related to the cost of processing the statements; and
   b. Not dependent upon the actual collection of payment.

C. Payment to physicians, dentists, or other health professionals. The Administration or a program contractor shall make payments to a physician, dentist or other health professional as follows:

1. To the employer of the physician, dentist or other health professional, if the physician, dentist, or other health professional is required, as a condition of employment, to relinquish fees to the employer;
2. To a foundation, plan, consortium, or other similar organization, including a health care service organization, that furnishes health care through an organized health care delivery system, if there is a contractual arrangement between the organization and the person furnishing the services under which the organization submits a claim for the services; or
3. To the facility in which the service is provided, if there is a contractual relationship between the facility and the physician, dentist, or other health professional furnishing the services under which the facility submits the claim for the services.

D. Prohibition of transfer of payments for program contractors or AHCCCS registered providers. A program contractor or an AHCCCS registered provider shall not assign all or part of AHCCCS payments for covered services furnished to a member to any party except as specified in this Section.

E. Prohibition of transfer of payments to factors. The Administration shall not make payment for covered services furnished to a member by a contractor, or an AHCCCS registered provider to, or through a factor, either directly, or by virtue of a power of attorney given to the factor.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 3340, effective July 15, 2002 (Supp. 02-3).

R9-28-705. Payments by Program Contractors

A. Authorization. A program contractor shall pay for all ALTCS covered services rendered to a member when the service or admission has been arranged by a program contractor's agent, an employee, a provider, or other individual acting on a program contractor's behalf, and for which necessary authorization has been obtained.

B. Timeliness of provider claim payment. A program contractor shall pay a claim or shall provide a notice for a denied or a reduced claim as specified in A.A.C. R9-22-705.

C. Payment for a long-term care service in an institutional and a home and community-based setting. A program contractor shall submit annually to the Administration, a program contractor's proposed payment methodology for reimbursement of a participating provider for long-term care services in an institutional and a home and community-based setting. All payment methods and rates of payment shall be subject to the approval of the Administration based on the reasonableness of the methods and rates. A program contractor shall use the following types of reimbursement:

1. The Administration's fee-for-service schedule;
2. Subcapitation;
3. Prospective payment when payment is tied to quality of care;
4. Volume purchase; and
5. Selective contracting and competitive bidding.

D. Payment for in-state medically necessary acute outpatient services. A program contractor shall reimburse an in-state provider and a noncontracting provider for the provision of medically necessary outpatient services to a program contractor's member.

E. Payment for acute inpatient hospital services and out-of-state hospital services. A program contractor shall reimburse a provider and a noncontracting provider for the provision of medically necessary inpatient hospital services to a program contractor's member.

F. Reimbursement standards for emergency services. A program contractor shall pay for all emergency care services rendered to a program contractor's member by a noncontracting provider or a provider when the services:

1. Are rendered according to the prudent layperson standard;
2. Conform to the definitions of emergency medical and acute mental health services defined in 9 A.A.C. 22, Article 1; and
3. Conform to the notification requirements in 9 A.A.C. 22, Article 2.

G. "."Transportation. A program contractor shall pay for ground or air ambulance transport in response to a 9-1-1 or other emergency response system call specified in A.A.C. R9-22-705.

Historical Note

Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective April 25, 1990 (Supp. 90-2). Amended under an exemption from the provisions of the Administrative Procedure Act, effective March 1, 1993 (Supp. 93-1). Amended effective November 5, 1993 (Supp. 93-4). Amended by final rulemaking at 5 A.A.R. 874, effective March 4, 1999 (Supp. 99-1).

R9-28-706. Payments by the Administration for Services Provided to Eligible Persons

A. Payment for medically necessary outpatient services.

1. The Administration shall pay for medically necessary outpatient services provided to eligible persons from the effective date of eligibility to the date of enrollment with

a program contractor at the negotiated rate, capped fee-for-service rate, or billed charges, whichever is lowest.

2. Eligible persons residing in areas that are not served by program contractors shall be eligible for ALTCS covered services. The Administration shall make payment for medically necessary outpatient services provided to these individuals at the negotiated rate, capped fee-for-service rate, or billed charges, whichever is lowest.
3. The Administration shall pay for medically necessary outpatient services provided to eligible persons by out-of-state providers at the capped fee-for-service rate under R9-28-708 or the Medicaid rate that is in effect at the time services are provided in the state in which the provider is located, whichever is lower.

B. The Administration shall make payment in accordance with A.A.C. R9-22-712 for covered hospital services provided to eligible persons on or after March 1, 1993.

C. Limitation on payment for hospital services. The Administration may limit payment for hospital services furnished to hospital inpatients who require a lower covered level of care, such as nursing facility services, to the cost of the lower or alternative level of care, when the Director or designee determines the less costly alternative could and should have been used by a hospital.

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended subsections (A) and (B) effective June 6, 1989 (Supp. 89-2). Amended effective April 25, 1990 (Supp. 90-2). Amended effective November 5, 1993 (Supp. 93-4). Amended effective September 22, 1997 (Supp. 97-3).

R9-28-707. Contractor's Liability to Hospitals for the Provision of Emergency and Subsequent Care
A contractor is liable to a hospital for the hospital's provision of emergency and subsequent care under A.A.C. R9-22-709, R9-28-705, and Article 2 of this Chapter.

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended under an exemption from the provisions of the Administrative Procedure Act, effective March 1, 1993 (Supp. 93-1). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 444, effective January 10, 2002 (Supp. 02-1).

Editor's Note: The following Section was amended under an exemption from the provisions of the Administrative Procedure Act which means that the amendment was not reviewed by the Governor's Regulatory Review Council; the agency did not submit a notice of proposed rulemaking for publication in the Arizona Administrative Register; the agency was not required to hold public hearings on the rulemaking; and the Attorney General has not certified the rule. This Section was subsequently amended through the regular rulemaking process.

R9-28-708. Capped Fee-for-service Payment

A. Service codes. A current copy of the code manuals listed below shall be maintained on file at the central office of the Administration for reference use during customary business hours.

1. The Physicians' Current Procedural Terminology (CPT) and Health Care Financing Administration Common Procedures Coding System (HCPCS) shall be utilized to identify medical services and procedures performed by physicians and other providers.
2. The Code on Dental Procedures and Nomenclature, as published in the Journal of the American Dental Association, shall be utilized to identify dental procedures.
3. The International Classification of Diseases.
4. The American Druggist Blue Book.

B. Fee schedule. The Administration shall pay providers and non-contracting providers at the capped fee-for-service rates specified below unless a different fee is specified by contract or otherwise required by this Article. Notice of changes in methods and standards for setting payment rates for services shall be in accordance with 42 CFR 447.205, January 18, 1984, incorporated by reference herein and on file with the Office of the Secretary of State.

1. ALTCS services. Payment shall be in accordance with the lower of the negotiated rate or fee schedules which are on file at the central office of the Administration for reference during customary business hours.
2. Physician services. Payment shall be in accordance with fee schedules which are on file at the central office of the Administration for reference use during customary business hours.
3. Hospital services. Hospital services provided to eligible persons shall be paid pursuant to A.A.C. R9-22-712.
4. Pharmacy services. Payment shall be in accordance with fee schedules which are on file at the central office of the Administration for reference use during customary business hours. The maximum allowable rates under the fee schedules shall not exceed the payment levels established pursuant to 42 CFR 447.331 through 447.332, incorporated by reference herein and on file with the Office of the Secretary of State.
5. Dental services. Payment shall be in accordance with fee schedules which are on file at the central office of the Administration for reference use during customary business hours.
6. Transportation services. Payment for transportation services shall be made in accordance with A.A.C. R9-22-710.
7. Medical equipment. Payment for medical equipment shall be in accordance with fee schedules which are on file at the central office of the Administration for reference use during customary business hours. Providers shall be reimbursed once for the durable medical equipment (DME) during any given two-year period, unless the Administration determines that DME replacement within that period is medically necessary for the member. Unless authorized by the Administration, no more than one repair and adjustment shall be reimbursed during any two-year period.

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective April 26, 1989 (Supp. 89-2). Amended under an exemption from the provisions of the Administrative Procedure Act, effective March 1, 1993 (Supp. 93-1). Amended effective November 5, 1993 (Supp. 93-4).

R9-28-709. Reinsurance
A program contractor shall submit to the Administration all reinsurance claims for services rendered to a member enrolled with the program contractor as specified in A.A.C. R9-22-720.

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended subsection (B) effective June 6, 1989 (Supp. 89-2). Amended effective September

22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 3340, effective July 15, 2002 (Supp. 02-3).

R9-28-710. Repealed

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended subsections (C) and (D) effective June 6, 1989 (Supp. 89-2). Amended effective September 22, 1997 (Supp. 97-3). Section repealed by final rulemaking at 8 A.A.R. 444, effective January 10, 2002 (Supp. 02-1).

R9-28-711. Payments Made on Behalf of a Program Contractor; Recovery of Funds; Postpayment Reviews

A. The Administration may make payments on behalf of a program contractor and may recover funds from a program contractor or AHCCCS registered provider according to standards under A.A.C. R9-22-713. For purposes of this Section, the term "contractor" as it appears in A.A.C. R9-22-713 means "program contractor."

B. The Administration shall conduct postpayment reviews of claims paid by the Administration and shall recoup any monies erroneously paid according to standards under A.A.C. R9-22-703. Program contractors may conduct postpayment reviews of claims paid by program contractors and may recoup any monies erroneously paid.

Historical Note
Adopted effective November 5, 1993 (Supp. 93-4). Amended effective September 22, 1997 (Supp. 97-3). Amended by final rulemaking at 8 A.A.R. 3340, effective July 15, 2002 (Supp. 02-3).

R9-28-712. County of Fiscal Responsibility

A. General requirements.
1. The Administration shall determine the county of fiscal responsibility under A.R.S. § 36-2913 for an applicant or member who is elderly or physically disabled.
2. A program contractor shall cover services and provisions specified in 9 A.A.C. 22, Articles 2 and 7 and Article 11 of this Chapter.

B. Criteria for determining county of fiscal responsibility for an applicant.
1. If the applicant resides in the applicant's own home, the county of fiscal responsibility is the county where the applicant currently resides.
2. This applies only if subsection (B)(3) does not apply. If the applicant is residing in a NF or alternative HCBS setting, the county of fiscal responsibility is the county in which the applicant last resided in the applicant's own home.
3. If the applicant moves from another state directly into a NF or alternative HCBS setting in this state, the county of fiscal responsibility is the county in which the person currently resides.
4. If the applicant moves from the Arizona State Hospital (ASH) into a NF or alternative HCBS setting, or is an inmate of a public institution moving from the public institution into a NF or alternative HCBS setting, the county of fiscal responsibility is the county in which the applicant resided in the applicant's own home prior to admission to ASH or the public institution.

C. Criteria for determining if there is a change in county of fiscal responsibility for a member moving from one county to another county.
1. No change in the county of fiscal responsibility. There is no change in the county of fiscal responsibility for a member if:
   a. The member moves from a NF to another NF in a different county,
   b. The member moves from a NF to an alternative HCBS setting in a different county,
   c. The member moves from an alternative HCBS setting to another alternative HCBS setting in a different county,
   d. The member moves from an alternative HCBS setting to a NF in a different county,
   e. The member moves from the member's own home to an alternative HCBS setting in a different county,
   f. The member moves from the member's own home to a NF in a different county,
   g. The member moves from a NF or alternative HCBS setting into ASH, or
   h. The member moves from ASH to a NF or alternative HCBS setting.
2. Change in the county of fiscal responsibility. If a member moves from one county to another, the county of fiscal of responsibility changes to the new county if the member moves from:
   a. An alternative HCBS setting to the member's own home in a different county,
   b. A NF to the member's own home in a different county,
   c. The member's own home to the member's own home in a different county, or
   d. ASH to the member's own home.
3. Transfers between program contractors. The county of fiscal responsibility changes if the Administration transfers a member from one program contractor to a different program contractor and if:
   a. Both program contractors agree, or
   b. The Administration determines that it is in the best interest of the member.

Historical Note
Adopted effective November 4, 1998 (Supp. 98-4). Amended by final rulemaking at 8 A.A.R. 3340, effective July 15, 2002 (Supp. 02-3).

R9-28-713. Hospital Rate Negotiations

A. A program contractor that negotiates with a hospital for inpatient services shall reimburse hospitals for a member's care under A.A.C. R9-22-715(A).

B. If the Administration negotiates or contracts with hospitals on behalf of program contractors for discounted hospital rates, the negotiated discounted rates shall be included in contracts between a program contractor and a hospital when in the best interest of the state.

C. The Director shall apportion any cost avoidance in the hospital component of provider capitation rates between the Administration and program contractor. The Administration's portion of the cost avoidance shall be reflected in reduced capitation rates paid to a program contractor.

Historical Note
New Section adopted by final rulemaking at 6 A.A.R. 896, effective February 8, 2000 (Supp. 00-1).

R9-28-714. Payments to Providers

The Administration shall pay providers under A.A.C. R9-22-714 and Article 2 of this Chapter.

Historical Note
New Section made by final rulemaking at 8 A.A.R. 444, effective January 10, 2002 (Supp. 02-1).

R9-28-715. Specialty Contracts
The Director may negotiate specialty contracts under A.A.C. R9-22-716.

Historical Note
New Section made by final rulemaking at 8 A.A.R. 444, effective January 10, 2002 (Supp. 02-1).

ARTICLE 8. REPEALED

Article 8, consisting of Sections R9-28-801 through R9-28-803, repealed by final rulemaking at 10 A.A.R. 820, effective April 3, 2004. The subject matter of Article 8 is now in 9 A.A.C. 34 (Supp. 04-1).

R9-28-801. Repealed

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective November 5, 1993 (Supp. 93-4). Section repealed; new Section adopted effective August 11, 1997 (Supp. 97-3). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 3365, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 820, effective April 3, 2004 (Supp. 04-1).

R9-28-802. Repealed

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective November 5, 1993 (Supp. 93-4). Section repealed; new Section adopted effective August 11, 1997 (Supp. 97-3). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 3365, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 820, effective April 3, 2004 (Supp. 04-1).

R9-28-803. Repealed

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Section repealed; new Section adopted effective August 11, 1997 (Supp. 97-3). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 3365, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 820, effective April 3, 2004 (Supp. 04-1).

R9-28-804. Repealed

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective April 25, 1990 (Supp. 90-2). Section repealed effective August 11, 1997 (Supp. 97-3).

ARTICLE 9. FIRST- AND THIRD-PARTY LIABILITY AND RECOVERIES

R9-28-901. Definitions
In addition to the definitions in A.R.S. §§ 36-2901 and 36-2931, 9 A.A.C. 22, Article 1, and 9 A.A.C. 28, Article 1, the following definition applies to this Article:

"Estate" has the meaning in A.R.S. § 14-1201.

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective November 7, 1997 (Supp. 97-4). Section repealed; new Section made by final rulemaking at 10 A.A.R. 1308, effective May 1, 2004 (Supp. 04-1).

R9-28-902. General Provisions
The provisions in A.A.C. R9-22-1002 apply to this Section.

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61, effective July 1, 1993 (Supp. 93-3). Amended effective November 7, 1997 (Supp. 97-4). Amended by final rulemaking at 10 A.A.R. 1308, effective May 1, 2004 (Supp. 04-1).

R9-28-903. Cost Avoidance
The provisions in A.A.C. R9-22-1003 apply to this Section.

Historical Note
New Section made by final rulemaking at 10 A.A.R. 1308, effective May 1, 2004 (Supp. 04-1).

R9-28-904. Member Participation
The provisions in A.A.C. R9-22-1004 apply to this Section.

Historical Note
New Section made by final rulemaking at 10 A.A.R. 1308, effective May 1, 2004 (Supp. 04-1).

R9-28-905. Collections
The provisions in A.A.C. R9-22-1005 apply to this Section.

Historical Note
New Section made by final rulemaking at 10 A.A.R. 1308, effective May 1, 2004 (Supp. 04-1).

R9-28-906. AHCCCS Monitoring Responsibilities
The provisions in A.A.C. R9-22-1006 apply to this Section.

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective November 7, 1997 (Supp. 97-4). Section repealed; new Section made by final rulemaking at 10 A.A.R. 1308, effective May 1, 2004 (Supp. 04-1).

R9-28-907. Notification for Perfection, Recording, and Assignment of AHCCCS Liens
The provisions in A.A.C. R9-22-1007 apply to this Section.

Historical Note
New Section made by final rulemaking at 10 A.A.R. 1308, effective May 1, 2004 (Supp. 04-1).

R9-28-908. Notification Information for Liens
The provisions in A.A.C. R9-22-1008 apply to this Section.

Historical Note
New Section made by final rulemaking at 10 A.A.R. 1308, effective May 1, 2004 (Supp. 04-1).

R9-28-909. Notification of Health Insurance Information
The provisions in A.A.C. R9-22-1009 apply to this Section.

Historical Note
New Section made by final rulemaking at 10 A.A.R. 1308, effective May 1, 2004 (Supp. 04-1).

R9-28-910. Recoveries
AHCCCS shall recover funds paid for ALTCS benefits including: capitation payments, Medicare Parts A and B premium payments, coinsurance and deductibles paid by AHCCCS, fee-for-service payments, and reinsurance payments from:
1. The estate of a member who was 55 years of age or older when the member received benefits; or
2. The estate or the property of a member under A.R.S. §§ 36-2935, 36-2956 and 42 U.S.C. 1396p.

Historical Note
New Section made by final rulemaking at 10 A.A.R. 1308, effective May 1, 2004 (Supp. 04-1).

R9-28-911. Undue Hardship
AHCCCS shall waive the recovery of funds because of undue hardship if either of the following situations exist:
1. When estate assets include real property or both real and personal property. There is property in the estate, and the property is listed as residential property by the Arizona Department of Revenue or County Assessor's Office, and the heir or devisee:
   a. Owns a business that is located at the residential property, and:
      i. The business was in operation at the residential property for at least 12 months preceding the death of the member;
      ii. The business provides more than 50 percent of the heir or devisee's livelihood; and
      iii. The recovery of the property would result in the heir losing the heir or devisee's means of livelihood; or
   b. Currently resides in the residence, and:
      i. Resided there at the time of the member's death,
      ii. Made the residence his or her primary residence for the 12 months immediately preceding the death of the member; and
      iii. Owns no other residence; or
2. When the estate assets contain personal property only, and:
   a. The heir or devisee's annual gross income for the household size is less than 100 percent of the Federal Poverty Level (FPL). New sources of income such as employment or Social Security that may not have yet been received, shall be included in determining the household's annual gross income; and
   b. The heir or devisee does not own a home, land, or other real property.

Historical Note
New Section made by final rulemaking at 10 A.A.R. 1308, effective May 1, 2004 (Supp. 04-1).

R9-28-912. Partial Recovery
AHCCCS shall use the following factors in determining whether to seek a partial recovery of funds when an heir or devisee does not meet the requirements of R9-28-911 and requests a partial recovery:
1. Financial and medical hardship to the heir or devisee;
2. Income of the heir or devisee and whether the heir or devisee's household gross annual income is less than 100 percent of the FPL;
3. Resources of the heir or devisee;
4. Value and type of assets;
5. Amount of AHCCCS' claim against the estate; and
6. Whether other creditors have filed claims against the estate or have foreclosed on the property.

Historical Note
New Section made by final rulemaking at 10 A.A.R. 1308, effective May 1, 2004 (Supp. 04-1).

ARTICLE 10. CIVIL MONETARY PENALTIES AND ASSESSMENTS

R9-28-1001. Basis for Civil Monetary Penalties and Assessments for Fraudulent Claims
The Director or designee shall impose a penalty and assessment under the circumstances described in A.R.S. § 36-2957. The Administration shall use the procedures detailed in 9 A.A.C. 22, Article 11 for the determination and collection of civil penalties and assessments.

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective June 6, 1989 (Supp. 89-2). Amended effective June 9, 1998 (Supp. 98-2).

R9-28-1002. Repealed

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective November 5, 1993 (Supp. 93-4). Repealed effective June 9, 1998 (Supp. 98-2).

R9-28-1003. Repealed

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Amended effective November 5, 1993 (Supp. 93-4). Repealed effective June 9, 1998 (Supp. 98-2).

R9-28-1004. Repealed

Historical Note
Adopted effective October 1, 1988, filed September 1, 1988 (Supp. 88-3). Repealed effective June 9, 1998 (Supp. 98-2).

ARTICLE 11. BEHAVIORAL HEALTH SERVICES

R9-28-1101. General Requirements
General requirements. The following general requirements apply to behavioral health services provided under this Article, subject to all exclusions and limitations.
1. Administration. The program shall be administered under A.R.S. § 36-2932.
2. Provision of services. Behavioral health services shall be provided under A.R.S. § 36-2939 and this Chapter.
3. Definitions. The following definitions apply to this Article:
   a. "Physician assistant" under A.R.S. § 32-2501. In addition, a physician assistant providing a behavioral health service shall be supervised by an AHCCCS-registered psychiatrist.
   b. "Respite" as defined under A.A.C. R9-22-1201.
   c. "Substance abuse" as defined under A.A.C. R9-22-1201.
   d. "Therapeutic foster care services" as defined under A.A.C. R9-22-1201.

Historical Note
Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61, effective November 1, 1992; received in the Office of the Secretary of State November 25, 1992 (Supp. 92-4). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 200, effective December 13, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4691, effective October 1, 2001 (Supp. 01-3).

R9-28-1102. Contractor Responsibilities

A. Contractor responsibilities. Contractors shall provide behavioral health services for members as specified in this Article.
1. A contractor shall determine whether a member needs behavioral health services and, if medically necessary, may subcontract through its service provider network for the behavioral health services in R9-28-1105.
2. A contractor shall coordinate the transition of care and medical records as specified in A.R.S. §§ 36-2932 and 36-509, A.A.C. R9-28-514, and in contract when a member transitions from:
   a. A behavioral health provider to another behavioral health provider,
   b. An RBHA to a contractor,
   c. A contractor to an RBHA, or
   d. A contractor to a contractor.
3. A contractor shall ensure that the member's medical records are transferred during the transition in this Section.

B. Administration responsibilities. If a contractor is not available to provide behavioral health services in a county, the Administration shall provide the service.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61, effective November 1, 1992; received in the Office of the Secretary of State November 25, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Ch. 204, § 11, effective October 1, 1995; filed with the Office of the Secretary of State September 29, 1995 (Supp. 95-4). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 200, effective December 13, 1999 (Supp. 99-4).

R9-28-1103. Eligibility for Covered Services

A. Eligibility for covered services. A member determined eligible under A.R.S. § 36-2934 shall receive medically necessary covered services specified in R9-28-1105.

B. Ineligibility. A person is not eligible for behavioral health services if the person is:
1. An inmate of a public institution as defined in 42 CFR 435.1009,
2. A resident of an institution for the treatment of tuberculosis, or
3. Age 21 through 64, who is a resident of an IMD, and who exceeds the limits under Article 11.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61, effective November 1, 1992; received in the Office of the Secretary of State November 25, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Ch. 204, § 11, effective October 1, 1995; filed with the Office of the Secretary of State September 29, 1995 (Supp. 95-4). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 200, effective December 13, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4691, effective October 1, 2001 (Supp. 01-3).

R9-28-1104. General Service Requirements

A. Services. Behavioral health services include both mental health and substance abuse services.

B. Medical necessity. A service shall be medically necessary as specified in R9-28-201.

C. Prior authorization. A service shall be provided by contractors, subcontractors, and providers consistent with prior authorization requirements established by the Director and under R9-28-1105.

D. EPSDT. For Title XIX members, EPSDT services shall include all medically necessary Title XIX-covered behavioral health services for a member.

E. Experimental services. The Director shall determine whether a service is experimental, or whether a service is provided primarily for the purpose of research. Those services shall not be covered.

F. Gratuities. A service or an item, if furnished gratuitously to a member by a provider, is not covered and payment shall be denied.

G. Service area. Behavioral health services rendered to a member shall be provided within the contractor's service area except when:
1. A contractor's primary care provider refers a member to another area for medical specialty care;
2. A member's medically necessary covered service is not available within the service area;
3. A net savings in behavioral health service delivery costs can be documented by the RBHA for a member. Undue travel time or hardship shall be considered for a member or a member's family; or
4. A member is placed in an NF or Alternative HCBS setting located out of the contractor's service area.

H. Travel. If a member travels or temporarily resides out of a behavioral health service area, covered services are restricted to emergency behavioral health care, unless authorized by the member's contractor.

I. Noncovered services. If a member requests a behavioral health service that is not covered by the Administration or is not authorized by a contractor, the behavioral health service may be provided by an AHCCCS-registered behavioral health service provider under the following conditions:
1. The requested service and the itemized cost of each service is documented by a contractor and provided to the member or the member's guardian; and
2. The member or member's guardian signs a statement acknowledging:
   a. Services have been explained to the member or member's guardian, and
   b. The member or member's guardian accepts responsibility for payment.

J. Referral. If a member is referred out of a contractor's service area to receive a prior authorized, medically necessary, behavioral health service or a medically necessary covered service, the service shall be provided by the contractor.

K. Restrictions and limitations.
1. The restrictions, limitations, and exclusions in this Article shall not apply to a contractor when electing to provide a noncovered service.
2. Room and board is not a covered service unless provided in an Level I, inpatient, sub-acute, or residential center under R9-28-1105.

L. Residential placement. Behavioral health services are covered in an Alternative HCBS setting or home as specified in R9-28-101(B).

M. Appropriate settings. A behavioral health service shall be provided in an allowable Alternative HCBS setting that meets

state and federal licensing standards and that is allowable under A.R.S. § 36-2939.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61, effective November 1, 1992; received in the Office of the Secretary of State November 25, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61, effective July 1, 1993; amended under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61, effective September 30, 1993 (Supp. 93-3). Amended under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Ch. 204, § 11, effective October 1, 1995; filed with the Secretary of State September 29, 1995 (Supp. 95-4). Amended under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Ch. 204, § 11, effective January 1, 1996; filed with the Office of the Secretary of State December 22, 1995 (Supp. 95-4). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 200, effective December 13, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4691, effective October 1, 2001 (Supp. 01-3).

R9-28-1105. Scope of Behavioral Health Services

A. Inpatient behavioral health services. The following inpatient services shall be covered subject to the limitations and exclusions in this Article.
1. Inpatient behavioral health services provided in a Medicare (Title XVIII) certified hospital include all behavioral health services, medical detoxification, accommodations and staffing, supplies, and equipment. The behavioral health service shall be provided under the direction of a physician in:
   a. A general acute care hospital, or
   b. An inpatient psychiatric hospital.
2. Inpatient service limitations:
   a. Inpatient services, other than emergency services specified in this Section, shall be prior authorized.
   b. Inpatient services shall be reimbursed on a per diem basis and shall be inclusive of all services and room and board, except the following may bill independently for services:
      i. A psychiatrist,
      ii. A certified psychiatric nurse practitioner,
      iii. A physician assistant,
      iv. A psychologist,
      v. A certified independent social worker,
      vi. A certified marriage and family therapist,
      vii. A certified professional counselor, or
      viii. A behavioral health medical practitioner.
   c. A member age 21 through 64 is eligible for behavioral health services provided in an IMD except as specified in 42 CFR 441.151 and under this Section up to 30 days per admission and no more than 60 days per contract year as allowed under the Administration's Section 1115 Waiver with CMS. These limitations do not apply to a member under age 21 and age 65 or over.

B. Level I Residential Treatment Center Services. The following Residential Treatment Center services shall be covered subject to the limitations and exclusions in this Article.
1. Level I Residential Treatment Center services shall be provided under the direction of a physician in a Level I Residential Treatment Center accredited by an AHCCCS approved accrediting body as specified in contract.
2. Residential Treatment Center services include room and board and treatment services for mental health and substance abuse conditions.
3. Residential Treatment Center service limitations:
   a. Services shall be prior authorized, except for emergency services as specified in this Section.
   b. Services shall be reimbursed on a per diem basis and shall be inclusive of all services, except the following may bill independently for services:
      i. A psychiatrist,
      ii. A certified psychiatric nurse practitioner,
      iii. A physician assistant,
      iv. A psychologist,
      v. A certified independent social worker,
      vi. A certified marriage and family therapist,
      vii. A certified professional counselor, or
      viii. A behavioral health medical practitioner.
4. The following services may be billed independently if prescribed by a provider specified in this Section:
   a. Laboratory,
   b. Radiology, and
   c. Psychotropic medication.

C. Level I Sub-acute Facility Services. The following sub-acute facility services shall be covered subject to the limitations and exclusions in this Article.
1. Level I sub-acute facility services shall be provided under the direction of a physician in a Level I sub-acute facility accredited by an AHCCCS approved accrediting body as specified in contract.
2. Level I sub-acute services include room and board and treatment services for mental health and substance abuse conditions.
3. Services shall be reimbursed on a per diem basis and shall be inclusive of all services, except the following may bill independently for services:
   a. A psychiatrist,
   b. A certified psychiatric nurse practitioner,
   c. A physician assistant,
   d. A psychologist,
   e. A certified independent social worker,
   f. A certified marriage and family therapist,
   g. A certified professional counselor, or
   h. A behavioral health medical practitioner.
4. The following services may be billed independently if prescribed by a provider specified in this Section:
   a. Laboratory,
   b. Radiology, and
   c. Psychotropic medication.
5. A member age 21 through 64 eligible for behavioral health services provided in an IMD except as specified in 42 CFR 441.151 as defined in this Section up to 30 days per admission and no more than 60 days per contract year as allowed under the Administration's Section 1115 Waiver with CMS. These limitations do not apply to a member under age 21 and age 65 or over.

D. ADHS licensed Level II Behavioral Health Residential Services. The following Level II Behavioral Health Residential services shall be covered subject to the limitations and exclusions in this Article.
1. Level II Behavioral Health services shall be provided by a licensed Level II agency.
2. Services shall be inclusive of all covered services except room and board.
3. The following may bill independently for services:
   a. A psychiatrist,
   b. A certified psychiatric nurse practitioner,

c. A physician assistant,
d. A psychologist,
e. A certified independent social worker,
f. A certified marriage and family therapist,
g. A certified professional counselor, or
h. A behavioral health medical practitioner.

E. ADHS licensed Level III Behavioral Health Residential Services. The following Level III Behavioral Health Residential services shall be covered subject to the limitations and exclusions in this Article.
1. Level III Behavioral Health services shall be provided by a licensed Level III agency.
2. Services shall be inclusive of all covered services except room and board.
3. The following may bill independently for services:
a. A psychiatrist,
b. A certified psychiatric nurse practitioner,
c. A physician assistant,
d. A psychologist,
e. A certified independent social worker,
f. A certified marriage and family therapist,
g. A certified professional counselor, or
h. A behavioral health medical practitioner.

F. Partial care. The following partial care services shall be covered subject to the limitations and exclusions in this Article.
1. Partial care shall be provided by an agency qualified to provide a regularly scheduled day program of individual member, group or family activities that are designed to improve the ability of the member to function in the community.
2. Partial care service exclusions. School attendance and educational hours shall not be included as a partial care service and shall not be billed concurrently with these services.

G. Outpatient services. The following outpatient services shall be covered subject to the limitations and exclusions in this Article.
1. Outpatient services shall include the following:
a. Screening provided by a behavioral health professional or a behavioral health technician;
b. Initial behavioral health evaluation provided by a behavioral health professional;
c. Ongoing behavioral health evaluation by a behavioral health professional or a behavioral health technician;
d. Counseling including individual therapy, group, and family therapy provided by a behavioral health professional or a behavioral health technician;
e. Behavior management services provided by qualified individuals or agencies as specified in contract; and
f. Psychosocial rehabilitation services provided by qualified individuals or agencies as specified in contract.
2. Outpatient service limitations:
a. The following practitioners may bill independently:
i. A psychiatrist,
ii. A certified psychiatric nurse practitioner,
iii. A physician assistant as defined in this Article,
iv. A psychologist,
v. A certified independent social worker,
vi. A certified professional counselor,
vii. A certified marriage and family therapist,
viii. A behavioral health medical practitioner,
ix. A therapeutic foster parent, and
x. Other AHCCCS registered providers as specified in contract.
b. Other behavioral health professionals and qualified persons not specified in subsection (G)(2)(a) shall be employed by, or contracted with, an AHCCCS-registered behavioral health agency.

H. Behavioral health emergency services. The following emergency services shall be covered subject to the limitations and exclusions in this Article.
1. Behavioral health emergency services may be provided on either an inpatient or outpatient basis. A contractor shall ensure services are provided by the qualified personnel specified in R9-28-1106. The emergency services shall be available 24 hours per day, seven days per week in the contractor's service area in situations when a member is a danger to self or others or is otherwise determined in need of immediate unscheduled behavioral health services.
2. An inpatient emergency service provider shall verify the eligibility and enrollment of a member through the Administration to determine the need for notification to a contractor, and to determine the party responsible for payment of services under Article 7.
3. Prior authorization for a consultation provided by a psychiatrist, a certified psychiatric nurse practitioner, a physician assistant, or a psychologist is not required if necessary to evaluate or stabilize a behavioral health emergency.
4. Inpatient behavioral health service limitations as specified in this Section apply to emergency services provided to a member on an inpatient basis.

I. Other behavioral health services. Other behavioral health services include:
1. Laboratory and radiology services for behavioral health diagnosis and medication management;
2. Psychotropic medication and related medication;
3. Medication monitoring, administration, and adjustment for psychotropic medication and related medications;
4. Respite care as defined in R9-28-1101;
5. Therapeutic foster care;
6. Personal assistance; and
7. Other support services to maintain or increase the member's self-sufficiency and ability to live outside an institution.

J. Transportation services.
1. Emergency transportation shall be covered for a behavioral health emergency under A.A.C. R9-22-211. Emergency transportation is limited to behavioral health emergencies.
2. Non-emergency transportation shall be covered to and from covered behavioral health service providers.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61, effective November 1, 1992; received in the Office of the Secretary of State November 25, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61, effective July 1, 1993 (Supp. 93-3). Amended under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1995, Ch. 204, § 11, effective October 1, 1995; filed with the Office of the Secretary of State September 29, 1995 (Supp. 95-4). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 200, effective December 13, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4691, effective October 1, 2001 (Supp. 01-3). Amended by exempt

rulemaking at 8 A.A.R. 933, effective February 12, 2002 (Supp. 02-1).

R9-28-1106. General Provisions and Standards for Service Providers

A. Qualified service provider. A qualified behavioral health service provider shall:
1. Be a non-contracting provider or employed by, or contracted in writing with, a contractor or a subcontractor to provide behavioral health services to a member;
2. Have all applicable state licenses or certifications, or comply with alternative requirements established by the Administration;
3. Register with the Administration as a behavioral health service provider; and
4. Comply with all requirements under Article 5 and this Article.

B. Quality and utilization management.
1. Service providers shall cooperate with the contractor's quality and utilization management, ADHS, and the Administration as under R9-28-511 and contract.
2. Service providers shall comply with applicable procedures under 42 CFR 456.

Historical Note

Adopted under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61, effective November 1, 1992; received in the Office of the Secretary of State November 25, 1992 (Supp. 92-4). Amended under an exemption from A.R.S. Title 41, Chapter 6, pursuant to Laws 1992, Ch. 301, § 61, effective July 1, 1993 (Supp. 93-3). Section repealed; new Section adopted by final rulemaking at 6 A.A.R. 200, effective December 13, 1999 (Supp. 99-4). Amended by exempt rulemaking at 7 A.A.R. 4691, effective October 1, 2001 (Supp. 01-3).

R9-28-1107. Standards for Payments

A. Payment to contractors. A payment to a contractor shall be made according to the terms and conditions of the contract executed with the Administration as specified in Article 7, unless otherwise specified in this Article.

B. Prior authorization. Payment to a provider for services or items requiring prior authorization may be denied if prior authorization is not obtained from the Administration, or a contractor as specified in R9-28-705.

Historical Note

New Section adopted by final rulemaking at 6 A.A.R. 200, effective December 13, 1999 (Supp. 99-4).

R9-28-1108. Grievance and Request for Hearing Process

A. Processing a grievance. A grievance for an adverse action for a behavioral health service shall be processed as specified in 9 A.A.C. 28, Articles 8 and 12 and under A.R.S. §§ 36-2932, 36-3413, and 41-1092 et seq. The grievance and request for hearing process is illustrated in 9 A.A.C. 22, Article 8, Exhibit A.

B. Member request for hearing. A member's request for hearing for a grievance under this Article shall be conducted under 9 A.A.C. 28, Article 8.

Historical Note

New Section adopted by final rulemaking at 6 A.A.R. 200, effective December 13, 1999 (Supp. 99-4). Amended by final rulemaking at 6 A.A.R. 3365, effective August 7, 2000 (Supp. 00-3).

ARTICLE 12. REPEALED

Article 12, consisting of Section R9-28-1201, repealed by final rulemaking at 10 A.A.R. 820, effective April 3, 2004. The subject matter of Article 12 is now in 9 A.A.C. 34 (Supp. 04-1).

R9-28-1201. Repealed

Historical Note

Adopted effective September 9, 1998 (Supp. 98-3). Amended by final rulemaking at 6 A.A.R. 3365, effective August 7, 2000 (Supp. 00-3). Section repealed by final rulemaking at 10 A.A.R. 820, effective April 3, 2004 (Supp. 04-1).

ARTICLE 13. FREEDOM TO WORK

Article 13, consisting of Sections R9-28-1301 through R9-28-1324, made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4).

R9-28-1301. General Freedom to Work Requirements

Under 42 U.S.C. 1396a(a)(10)(A)(ii)(XV) and (XVI), the Administration shall determine eligibility for AHCCCS medical services, under Article 2 of this Chapter, using the eligibility criteria and requirements under this Article for an applicant or member who is:
1. At least 16 years of age, but less than 65 years of age,
2. Employed, and
3. Not income or resource eligible under A.R.S. § 36-2934.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4).

R9-28-1302. General Administration Requirements

The Administration shall comply with the confidentiality rule under R9-28-401(H), Title VI compliance rule under R9-28-401(I) and transitional rule under R9-28-411(E). Terms used in this Article are defined in Article 1 of this Chapter unless otherwise specified.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4).

R9-28-1303. Application for Coverage

A. A person may apply by submitting a signed application to an Administration office.

B. The application date is the date the application is received at an Administration office.

C. The provisions of A.A.C. R9-22-1405(B), (C), and (E) apply to this Section.

D. An applicant or representative who files an application may withdraw the application for coverage either orally or in writing. The Administration shall send an applicant withdrawing an application a denial notice under R9-28-1304.

E. Except as provided in 42 CFR 435.911, the Administration shall determine eligibility within 45 days.

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4). Amended by final rulemaking at 9 A.A.R. 5138, effective January 3, 2004 (Supp. 03-4).

R9-28-1304. Notice of Approval or Denial

The Administration shall send an applicant a written notice of the decision regarding the application. This notice shall include a statement of the action, and:
1. If approved, the notice shall contain:
   a. The effective date of eligibility,
   b. The amount the person shall pay, and

c. An explanation of the person's hearing rights specified in Article 8 of this Chapter.

2. If denied, R9-28-401(G)(2) applies.

Historical Note
New Section made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4).

R9-28-1305. Reporting and Verifying Changes
An applicant or member shall report, as described under R9-28-411(A)(2), (3), (4), and (5), to the Administration the following changes:

1. Change of address,
2. Change in income,
3. Change in employment status,
4. Change in school attendance if under age 22,
5. Change in Arizona state residency;
6. Change in first- or third-party liability which may contribute to the payment of all or a portion of the person's medical costs,
7. Admission to a public institution,
8. Admission to an Institution for Mental Disease,
9. Improvement in the person's medical condition,
10. Death,
11. Change in U.S. citizenship or immigrant status,
12. Change in disability status,
13. Change in spouse's income that may affect the share of cost,
14. Change in impairment related work or other expenses, or
15. Any other change that may affect the member or applicant's eligibility or share of cost.

Historical Note
New Section made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4).

R9-28-1306. Actions that Result from a Redetermination or Change
The processing of a redetermination or change shall result in one of the following actions:

1. No change in eligibility, share-of-cost, or premium,
2. Discontinuance of eligibility if a condition of eligibility is no longer met,
3. A change in the person's share-of-cost,
4. A change in premium amount, or
5. A change in the coverage group under which a person receives AHCCCS medical coverage.

Historical Note
New Section made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4).

R9-28-1307. Notice of Adverse Action Requirements

A. The requirements under R9-28-411(D)(1) apply.

B. Advance notice of a change in eligibility, share of cost, or premium amount. Advance notice means a notice of proposed action that is issued to the member at least 10 days before the effective date of the proposed action. Except under subsection (C), advance notice shall be issued whenever an adverse action is taken to:

1. Discontinue eligibility,
2. Increase a person's share-of-cost;
3. Increase the premium amount, or
4. Reduce benefits from ALTCS to acute care services.

C. Exceptions from advance notice. A notice shall be issued to the member to discontinue eligibility no later than the effective date of action if:

1. A member provides a clearly written statement, signed by that member, that services are no longer wanted.
2. A member provides information that requires termination of eligibility and a member signs a written statement waiving advance notice;
3. A member cannot be located and mail sent to the member's last known address has been returned as undeliverable subject to reinstatement of discontinued services under 42 CFR 431.231(d);
4. A member has been admitted to a public institution where a person is ineligible for coverage;
5. A member has been approved for Medicaid in another state; or
6. The Administration receives information confirming the death of a member.

Historical Note
New Section made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4).

R9-28-1308. Request for Hearing
An applicant or member may request a hearing under Article 8 of this Chapter for the following adverse actions:

1. The determination of a premium amount under R9-28-1322, and
2. Actions listed in R9-28-803.

Historical Note
New Section made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4).

R9-28-1309. Social Security Number
As a condition of eligibility, an applicant shall furnish a valid SSN.

Historical Note
New Section made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4).

R9-28-1310. State Residency
As a condition of eligibility, an applicant or member shall be a resident of Arizona.

Historical Note
New Section made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4).

R9-28-1311. Citizenship and Immigrant Status
As a condition of eligibility an applicant or member shall be a citizen of the United States, or shall meet requirements for qualified alien under A.R.S. § 36-2903.03(B).

Historical Note
New Section made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4).

R9-28-1312. Age
As a condition of eligibility an applicant or member shall be at least 16 years of age, but less than 65 years of age.

Historical Note
New Section made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4).

R9-28-1313. Premium
As a condition of eligibility, an applicant or member shall pay the premium required under R9-28-1322.

Historical Note
New Section made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4).

R9-28-1314. Income
As a condition of eligibility, an applicant or member's countable income shall not exceed 250 percent of FPL. The Administration

shall count the income under 42 U.S.C. 1382a and 20 CFR 416 Subpart K with the following exceptions:

1. The unearned income of the applicant or member shall be disregarded,
2. The income of a spouse or other family members shall be disregarded, and
3. The deduction for a minor child shall not apply.

Historical Note
New Section made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4).

R9-28-1315. Living Arrangement
As a condition of eligibility, an applicant or member shall reside in a living arrangement defined under R9-28-406(A).

Historical Note
New Section made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4).

R9-28-1316. Institutionalized Person
A person is not eligible for AHCCCS medical coverage if the person is:

1. An inmate of a public institution if federal financial participation (FFP) is not available, or
2. Age 21 through age 64 and is residing in an Institution for Mental Disease under 42 CFR 435.1009 except when allowed under the Administration's Section 1115 IMD waiver with CMS.

Historical Note
New Section made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4).

R9-28-1317. Medical Eligibility
As a condition of eligibility, an applicant or member shall meet the medical criteria under Article 3 of this Chapter.

Historical Note
New Section made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4).

R9-28-1318. Non Payment of Premium
As a condition of eligibility, an applicant shall not have unpaid premiums as defined under R9-28-1322.

Historical Note
New Section made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4).

R9-28-1319. Applicant and Member Responsibility
As a condition of eligibility, an applicant or member shall comply with the provisions under A.A.C. R9-22-1502(D) and R9-22-1502(F).

Historical Note
New Section made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4).

R9-28-1320. Additional Eligibility Criteria for the Basic Coverage Group
An applicant or member shall meet the following eligibility criteria:

1. Disabled. An applicant or member shall meet the requirements under Article 3 of this Chapter.
2. Employed. As a condition of eligibility, an applicant or member shall be employed. Employed means that an applicant or member is paid for working and Social Security or Medicare taxes are paid on the applicant's or member's work.

Historical Note
New Section made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4).

R9-28-1321. Share of Cost
The Director shall determine the amount a person shall pay for the cost of ALTCS services (share-of-cost) under A.R.S. § 36-2932(L) and 42 CFR 435.725 or 42 CFR 435.726. Share of cost shall be calculated for people who reside in a medical institution for an entire calendar month under R9-28-408(G) and R9-28-410(C) except that the personal-needs allowance shall be increased by 50 percent of the member's earned income.

Historical Note
New Section made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4).

R9-28-1322. Premium Amount
The Administration shall process premiums under Article 14 of this Chapter with the following exceptions:

1. A member who resides in a HCBS setting under R9-28-406(A)(2) and has countable income:
   a. Under $500, the monthly premium payment shall be $0.
   b. Over $500 but not greater than $750, the monthly premium payment shall be $10.
2. The premium for a member who resides in a HCBS setting under R9-28-406(A)(2) shall be increased by $5 for each $250 increase in countable income above $750.
3. For a member living in a medical institution for a full calendar month, the monthly premium payment shall be $0.

Historical Note
New Section made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4).

R9-28-1323. Enrollment
The Administration shall enroll members under R9-28-412 through R9-28-418.

Historical Note
New Section made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4).

R9-28-1324. Redetermination of Eligibility

A. Redetermination. Except as provided in subsection (B), the Administration shall complete a redetermination of eligibility at least once a year.

B. Change in circumstance. The Administration may complete a redetermination of eligibility if there is a change in the member's circumstances, including a change in disability or employment that may affect eligibility.

C. Medical Improvement. If a member is no longer disabled under Article 3 of this Chapter, the Administration shall determine if the member is eligible under other coverage groups.

Historical Note
New Section made by exempt rulemaking at 9 A.A.R. 99, effective January 1, 2003 (Supp. 02-4).